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ABSTRACT

These modules are intended as a guide for developing short-term training workshops for paraprofessional service providers in aging. They are for use by trainers with some basic familiarity with the topic; use of teams of educators and practitioners as trainers is suggested to bridge the gap between knowledge and practice. A section on "Training Professionals as Trainers," by Debra David and Susan Golden Feinberg, covers the need for paraprofessional training, project goals, setting, recruitment of participants for a workshop to train trainers, selection criteria, the workshop on training methods and skills, workshop topics, sample agenda, evaluation, products, and future plans. Eight competency-based workshop modules are provided, each suitable for a one-day workshop for paraprofessional service providers in aging. Topics are working with families of older adults, matching older clients and services, reaching the minority elderly, dealing with death, managing behavioral problems of older adults, assessment of older clients, meeting the psychosocial needs of the homebound elderly, and working with the confused elderly. Each modular curriculum guide includes a synopsis, rationale, annotated listings of printed and media resources, a topic outline relating topics to student competencies and suggested presentation methods, assessment questions, and a suggested schedule for a one-day workshop. (YLB)

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ED246261

EIGHT COMPETENCY-BASED MODULES FOR TRAINING PARAPROFESSIONALS IN APPLIED GERONTOLOGY

Elgin Community College Gerontology Program
1700 Spartan Drive
Elgin, IL 60120

January 1984

CE039306

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INTRODUCTION

This module was developed as part of a project funded by a Gerontology Career Preparation Grant from the Administration on Aging which ran from October, 1982, to February, 1984. It was designed to be used as a guide for developing short-term training workshops for paraprofessional service providers in aging. It was field-tested in a one-day workshop delivered by a gerontology faculty member and one or two professional practitioners in aging network agencies.

It is competency-based, that is, designed to enable trainees to develop specific skills, knowledge, and attitudes which they will actually use in human service practice with older clients. They focus on the development of problem-solving abilities which can be applied across situations and settings: how to conceptualize a situation; how to formulate, implement, and evaluate an intervention plan; how to cope with challenging situations; and when, where, and how to seek information and assistance.

In our experience, trainee motivation and performance are improved if the instructor clearly states the competencies which the trainees are expected to master. It is also helpful to share the rationales for each module so that trainees recognize the relevance of the materials to their goals.

It will be necessary for trainers to be selective in designing a workshop agenda from these materials, because we have included more competencies and suggested presentation methods than can be realistically covered in a short-term program. We have chosen to do this so that trainers can adapt the module to the specific needs of the trainees, the available time, and their own training styles.

We strongly recommend that instructors vary their presentation methods. Trainees learn in different ways and variety stimulates trainee interest. Traditional lectures (supplemented by handouts and/or audio-visual illustrations) are particularly appropriate for presenting cognitive information, but skills and attitudes are usually fostered more effectively through discussion, practical exercises, simulations, problem-solving groups, and other experiential methods.

The amount of time devoted to each topic is up to the trainers. If the trainees are relatively unsophisticated about gerontology, it will probably be appropriate to spend more time on the first topics in the module, which emphasize background information. If the trainees are highly experienced and knowledgeable, it will probably be appropriate to spend more time on later topics, which emphasize application to practice. We do not suggest mixing trainees of widely varied backgrounds because of differences in training needs. The focus of the workshop (basic or advanced) should be clearly publicized so that participants have realistic expectations. (We do "check in" with participants about their expectations at the beginning of workshops, but that is usually too late to make major adjustments in the agenda.)

The module is intended to be used by trainers who have some basic familiarity with the topic and awareness or current practice. The resources listed can be useful in strengthening one's knowledge base but are seldom strongly applied. Our use of teams of educators and practitioners as trainers helped us to bridge the gap between knowledge and practice.

We hope that you find these materials to be helpful. For more information about the project and about other paraprofessional curriculum materials, contact: Gerontology Program, Elgin Community College, 1700 Spartan Drive, Elgin, IL 60120.

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TRAINING PROFESSIONALS AS TRAINERS

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TRAINING PROFESSIONALS AS TRAINERS

THE NEED:

Paraprofessionals - often the front-line workers in services to older adults - seldom receive formal training in gerontology. If they receive training at all, it is usually provided through in-service sessions by agency professionals who are knowledgeable about practice but seldom prepared for their training roles. Agencies are generally unwilling to support much travel, release time, or tuition assistance for paraprofessional training, so training programs must be local, short-term, and low-cost. Because institutions of higher education have focused mainly on professional and pre-professional gerontology training, appropriate programs and resource materials for paraprofessionals are limited.

In the Elgin Community College district, local need for paraprofessional training was demonstrated by high attendance at a series of applied gerontology workshops, participant surveys, agency surveys, and discussion with an advisory of community practitioners in aging. Although the workshop series had begun to address that need with considerable success, they were supported by outside funding which ended in June, 1982. The funding had enabled the college to bring in visiting experts; the cost for those experts prohibited continuing those workshops. Faculty in the gerontology associate degree program did not have sufficient time to offer workshops regularly. Also, the workshops themselves did not result in replicable resources, nor were they always directly related to paraprofessional roles.

PROJECT GOALS:

To address the on-going local need for quality paraprofessional training and the general need for useful resource materials, the project was designed to:

*Train sixteen professionals from aging network agencies to design and deliver competency-based training workshops for paraprofessionals.

*Develop curriculum materials on eight topics in applied gerontology with high relevance to paraprofessionals.

*Offer eight paraprofessional workshops which would reach at least 240 workers, provide an opportunity for the professionals to gain guided experience with feedback, and field-test the curriculum materials.

*Establish a mechanism for continuing to offer paraprofessional workshops on a cost-effective basis using the trained professionals.

*Disseminate project materials and results nationally.

THE SETTING:

Elgin Community College is a public, comprehensive two-year college which offers credit programs for transfer to four-year institutions and for vocational-technical training. It also offers a wide range of non-credit continuing education activities. Located on the western fringe of the Chicago metropolitan area, it serves a varied district of urban, suburban, and rural communities. District population is about 220,000, including about 28,600 residents over age 60.

HISTORY:

Since Fall, 1978, Elgin Community College has had a Gerontology Program. NIMH support enabled the college to develop and institutionalize a model associate degree curriculum in aging and mental health. The NIMH grant also provided funds for visiting lecturers, who were used primarily to offer short-term training workshops for aging network practitioners as well as gerontology students.

The college worked closely with aging network agencies from the Gerontology Program's inception. Local agencies were consulted in a needs assessment. A community advisory committee of aging network practitioners helped to identify curriculum goals. Many agencies provided tuition support and/or release time for staff to attend credit and non-credit courses. They also served as field practicum sites for associate degree students.

The closest college/agency collaboration developed in the area of short-term training. The topics were selected with aging network guidance, many workshops were co-sponsored, and sometimes agency facilities and/or staff were used to help deliver the training. The college was invited to jointly plan and implement many aging network training activities outside regular college programs. When NIMH support ended in June, 1982, funds for visiting lecturers ended and availability of gerontology staff for other training was greatly reduced.

CURRENT PROJECT:

This project, funded in part by an AoA Career Preparation grant, involves extensive collaboration between the college and the aging network. The community advisory committee helped to plan the proposal and identify topics for paraprofessional training. Committee members and professionals from Title III-funded agencies were given priority for the "training-the-trainer" program. Aging network professionals were also actively used in workshop planning, curriculum review, and evaluation. The main audience reached by the paraprofessional workshops are current practitioners. Partial tuition support is also available for workers enrolling in the associate degree program.

The most unique collaborative aspect is the development of an on-going training network. A major goal is to use the professionals involved in the "training-the-trainer" program to continue offering continuing education workshops at the college (and elsewhere) on an inexpensive basis. The college "pays" the professionals for their services through "fee waivers" which permit agency staff and volunteers to take the paraprofessional workshops for free. When the current project ends, trainers will have the option of choosing either fee waivers or modest honoraria for their services.

The aging network benefits from this project through increased expertise of the professionals, continued availability of training for the paraprofessionals, contact with college gerontology faculty, access to college resources, and interaction with other program participants. The college benefits from increased sensitivity of faculty to the current needs of the aging network, program visibility, enrichment of the Gerontology Program through the workshops, and training resources to continue to offer paraprofessional programs on a cost-effective basis.

RECRUITMENT:

The main method of recruitment was a flier sent to all agencies serving older adults within commuting distance. The flier described the "training-the-trainer" workshop goals, team-teaching, fee waiver arrangement, visiting lecturers, and application requirements. Members of the Community Advisory Committee were also contacted in person or by phone.

SELECTION CRITERIA:

The minimum reqirements for application included: 1) Baccalaureate degree or professional license plus one year experience in aging plus six credits or gerontology coursework; or 2) Baccalaureate degree or professional license plus two years experience in aging with no gerontology coursework; or 3) Associate degree plus two years experience in aging plus six credits of gerontology coursework.

Preference was given to members of the Community Advisory Committee and to professionals from agencies receiving Older Americans Act funds.

PARTICIPANTS AND THEIR BACKGROUNDS:

The selected professionals were:

Gayle Allen-Burket, B.S. (Therapeutic Recreation), nursing home consultant in private practice
Joyce Bean, M.S. (Marriage and Family Relations), therapist-caseworker, Older Adults Program, Family Service Association of Elgin
Susan Cincinelli, A.A., executive director, Oak Crest Residence
Maynette Collins, A.A., outreach worker, YMCA Third Age Nutrition Program
Robert Crocker, M.A. (Theology), district superintendent, United Methodist Church
Lucy Dvorak, B.A. (Education), director, Senior Counseling Program, Elk Grove-Schaumburg Mental Health Center
Betty Jones. B.A. (Education), volunteer coordinator, Senior Counseling Program, Elk Grove-Schaumburg Mental Health Center
Linda McCauley, B.S. (Applied Behavioral Science), social service caseworker Bensenville Home Society
Ellen McDonald, B.A. (Biology), residential services social worker, Elgin Mental Health Center
Joan Needham, M.S. (Education), director of staff education, DeKalb County Nursing Home
Joyce Palmquist, M.S. (Gerontology), case manager, Elk Grove-Schaumburg Mental Health Center
Barbara Parot, B.S. (Family Social Service), caseworker, Senior Services, Family Service Association of DeKalb
Cheryl Price, M.S.W., medical social worker, KSB Hospital
Mary Schalow, M.S. (Adult Continuing Education), director of educational services, St. Joseph Hospital
Barbara Tyrell, M.S.W., social worker/therapist, Elk Grove-Schaumburg Mental Health Center

COMPONENTS:

The training-the-trainer curriculum consisted of three components:
1) a one-day workshop on methods and skills for designing and delivering competency-based training;
2) team-teaching an actual competency-based workshop for paraprofessionals with a college gerontology faculty member; and
3) attending presentation by visiting lecturers.

WORKSHOP ON TRAINING METHODS AND SKILLS

Each professional attended a one-day workshop. To keep the groups small enough to give each person individualized feedback, the workshop was offered twice, with about half of the professionals attending each session. Training was conducted by three Gerontology Program staff members.

The goals of the workshop were to enable the professionals to:

*Understand the basic principles of competency-based training for adult learners.

*Become more familiar with a variety of training methods.

*Learn and practice group facilitation skills, particularly as applied to group discussion and role playing.

*Design a brief learning experience.

*Present and get feedback on an actual learning activity.

*Understand the logistics of the training-the-trainer program.

The session also gave participants an opportunity to become acquainted with each other. Lists of useful books and audio-visual resources were distributed, with information about how to obtain these materials.

The morning portion of the workshop covered introductions, training principles and methods, group discussion and role playing, resources, and program logistics. In the afternoon portion, participants worked in twos or threes to design and present brief, competency-based learning activities. Their presentations were video-taped and critiqued.

THE TEAM-TEACHING EXPERIENCE

Teams consisting of two aging network professionals and one college gerontology faculty member were formed. Each team delivered one of a series of eight competency-based workshops for paraprofessionals. The workshops, scheduled over an eight-month period, reached nearly 300 trainees.

Topics for the paraprofessional workshop had been previously identified with guidance from the community advisory committee. Modular curriculum guides for each topic were prepared by experts, half from the college faculty, half by outside consultants. The topics and their developers were:

FIGURE 1

TRAINING THE TRAINER WORKSHOP

SAMPLE AGENDA

9:00 - 9:30 am	Introductions Overview of the Workshop	
9:45 - 10:15	Training Methods for Adult Learners	
10:15 - 10:30	Break	
10:30 - 11:30	Group Facilitation Skills	
11:30 - 12:00	Overview of Resources for Gerontology Training Principles of Competency-Based Education	
12:00 - 1:00 pm	Lunch	
1:00 - 1:15	How to Develop Presentations	
1:15 - 1:45	Participants will Develop Presentations	
1:45 - 2:10	Group I	(Each group will develop a 5-10 minute presentation which will be videotaped. After each presentation the videotape will be replayed and discussion will follow.)
2:10 - 2:35	Group II	
2:35 - 4:00	Group III	
4:00 - 4:25	Group IV	
4:25 - 4:30	Wrap-up and evaluation.	

*Matching Older Clients and Services - Debra David, Ph.D., Elgin Community College

*Meeting the Psychosocial Needs of Homebound Elders - June Soderstrom, Elgin Community College

*Helping Elders Deal with Death - Michel Barbezat, Elgin Community College

*Working with Families of Older Adults - James Ellor, D.Min., University of Chicago, and Debra David, Ph.D., Elgin Community College

*Managing Behavioral Problems in Older Adults - Nathan Linsk, Ph.D., University of Chicago

*Working with the Confused Elderly - James Ellor, D.Min., University of Chicago

*Outreach to Minority Elders - Peggye Dilworth-Anderson, Ph.D., Northeastern Illinois University

*Assessment of Older Clients - Angela Falcone, Cornell Medical Center

Each curriculum guide included a synopsis, rationale, printed and media resources, topic outline, trainee competencies, suggested presentation methods, assessment questions, and a suggested schedule for a one-day workshop.

The teams of professionals and faculty members met (usually twice) before their workshops to develop the day's agenda and allocate parts of the training. While they used the curriculum modules as resources, each team was free to use or adapt those modules as they chose.

After presenting the workshops, team members met again to discuss how it went and to give each other feedback about their training skills. Each team member also evaluated the curriculum guide using a questionnaire.

VISITING LECTURERS

The aging network professionals were encouraged to attend a series of workshops provided by visiting lecturers. The visiting lecturers gave the professionals an opportunity to observe and analyze training models of other trainers as well as to enrich their knowledge base. In most cases, the professionals were invited to join the visiting lecturer for discussion over lunch. The workshops were free to training-the-trainer participants, but were also open to the public for a small fee.

Specific programs and their presenters included the following:

*Growing Older, Staying Healthy: Promoting Health Among Older Adults, by Robert Skeist, Augustana Hospital

*Self-Help Groups for Older Adults, by Patricia Connelley, psychiatric nurse in private practice.

*Confusion in the Elderly (co-sponsored with Elgin Mental Health Center), by Lawrence Lazarus, M.D., Illinois State Psychiatric Institute; Ken Dellefield, Johnston R. Bowman Health Care Center; James Ellor, D.Min., University of Chicago; Nathan Linsk, Ph.D., University of Chicago; and Bridget Stafford, Ph.D., Central DuPage Hospital.

*Women in Later Life, by Peggye Dilworth-Anderson, Ph.D., Northeastern Illinois University

*Old and Young Together: Intergenerational Programming, by Fern Crane, Ed.D., private practice; Ann Gale, Ph.D., Chicago Office of Senior Citizens and Handicapped; Betty Jones, Elk-Grove-Schaumburg Mental Health Center; Sherri Szwiec, Plum Grove Nursing Center; Gary Roberts, American Association of Retired Persons; Henrietta Moore, Chicago Gray Panthers; and Lucy Dvorak, Elk Grove-Schaumburg Mental Health Center.
(Jones and Dvorak were participants in the training-the-trainer program and helped to plan this workshop)

At least two more visiting lecture workshops will given before the project ends in February, 1984.

EVALUATION:

Several segments of the "Training-the-Trainer" program have been evaluated, but a summative program evaluation by participants is to be conducted in early December, 1983.

The one-day workshops on training methods and skills were immediately assessed by the professionals. The average rating was slightly above 4.5 on a 5-point scale, indicating general high satisfaction. The most frequent criticism was that some participants would have preferred to spend more time on actual training practice and feedback. Some suggested that the section on group discussion and role playing could be condensed. Prepared handouts on gerontology resources and on various training and presentation methods were particularly well-received.

The team-teaching performance of the professionals conducting paraprofessional workshops was rated by the paraprofessionals. The average rating was slightly below 4.0 on a 5-point scale, which project staff considered somewhat disappointing. In general, those professionals who receive the highest ratings were those with the most prior experience as trainers. This suggests that the training-the-trainer program in itself was not adequate to prepare new trainers. Informal feedback from the less-experienced trainers indicated that they felt that not enough time was spent by the teaching teams in workshop planning. If we were to repeat the project, we would probably encourage a minimum of three planning sessions and/or have less experienced trainers work individually with the faculty member rather than in pairs.

In December, the professionals will complete a more detailed questionnaire on the strengths and limitations of the program and its impact on their training activities and skills.

PRODUCTS:

Training Curricula - The project produced a training curriculum for training the aging network professionals and eight competency-based workshop modules designed for paraprofessionals (see previous section on the team-teaching experience for topics). Each professional participating in the project will receive a copy of all eight workshop modules. All training curricula will also be available to interested persons nationally.

Directory - A directory of the professionals who completed the training program, listing their background, addresses, phones, and topics which they feel competent to teach is currently being compiled. It will be sent to all aging network agencies and colleges within commuting distance of the college in order to encourage them to use the skills of the trainers.

FUTURE PLANS:

Elgin Community College plans to use the skills of the trained professionals to deliver inexpensive, quality continuing education programs for aging network practitioners. In the future, trainers will have the option of choosing fee waivers or modest payment for their services. Beyond the college, it is anticipated that those aging network professionals who participated in the "training-the-trainer" program will be able to use their experience to offer more paraprofessional training in their own agencies and communities.

WORKSHOP MODULE

James W. Ellor, D.Min., CSW, ACSW, and
Debra David, Ph.D.

TOPIC:

Working with Families of Older Adults

SYNOPSIS:

Using a family systems model, this workshop explores approaches to working with aging parents and their adult children. Assessment, intervention techniques, and community resources to aid elders and their families are covered.

RATIONALE:

Contrary to popular myth, the family is the main source of help for most older people, particularly in times of stress. A full understanding of the situation of an older person must take account of those family supports. This workshop focuses on relationships between aging parents and adult children from a family systems perspective, examining the highly variable nature of those relationships, assessment, intervention approaches, and community resources to aid families. It emphasizes problems which human service workers are likely to encounter among their clients' families and suggests some ways to understand and deal with those problems.

Human service workers frequently interact with the adult child(ren) of an elderly client. The child(ren) can be an important resource in developing the most effective service plan for the client. However, the needs of the entire family system - the client, the adult child(ren), and other involved relatives - must be considered, for when any family member is experiencing stress, other members are likely to be affected. At times, unresolved family conflicts (such as sibling rivalry, parent-child value differences, in-law problems) may be additional sources of stress which need attention. Appropriate roles for human service workers to play in working with aging parents and their adult child(ren) are also discussed in this workshop.

RESOURCES:

A. Printed Materials

Eyde, Donna R. and Rich, Jay A., Psychological Distress in Aging/A Family Management Model, Rockville, Md., Aspen Publications, 1983.

This new book contains a wealth of information that ranges from a review of family concerns, to assessment, to suggestions, for support of the family care takers. This superb book is a useful resource for professionals in health and related fields.

Hackett, Kenrick W., "On the Family Life Cycle and Intergenerational Relationships," Journal of Gerontological Social Work, Vol. 2, Number 2, Winter, 1979, pp. 95-107.

This important article uses a longitudinal approach to the family relations of the aged.

Helphand, M., and Porter, C.M., "The Family Group within the Nursing Home: Maintaining Family Ties of Long-Term Care Residents," Journal of Gerontological Social Work, Vol. 4, Number 1, Fall, 1981, pp. 51-62.

This article explores the need for and utility of family groups, as an approach to the support of families who elect to place older family members into long term care facilities.

Herr, J. J. and Weakland, J. H., Counseling Elders and Their Families, New York, New York, Springer Press, 1979.

This book provides an excellent resource for therapists who work with the elderly. It is based on a family systems approach and directed toward "applied gerontologists." Includes good case materials.

Silverstone, B.,"Family Relationships of the Elderly: Problems and Implications for Helping Professionals," Aged Care and Services Review, Volume 1, Number 2, March/April, 1978, pp. 1-9.

This article provides a comprehensive review of the literature on family relationships of the elderly.

Troll, L. E., Miller, S. J., Atchley, R. C., Families in Later Life, Belmont, California, Wadsworth Publishing Co., Inc., 1979.

This book provides a useful resource for the statistics and research on families in later life.

Weeks, J. R., and Cuellar, J. B., "The Role of Family Members in the Helping Networks of Older People," The Gerontologist, Volume 21, Number 4, 1981, pp. 388-394.

This article discusses the family in light of the recent literature on helping networks. Informal helpers have traditionally been an important resource for the elderly.

B. Audiovisual Materials

Peege (film)

This 28-minute film shows the awkward visit of a family to a very impaired grandmother in a nursing home and one grandson's effort to communicate with her through shared memories. It has become a classic in aging media and is very moving. Available for rent from many universities, including University of Illinois, Iowa State, North Texas State, Penn State, and UCLA.

When Parents Grow Old (film)

A 14-minute excerpt from the feature film, "I Never Sang for My Father," this explores the issue of children's responsibility to aging parents. The family shown has a history of parent-child conflict and sibling rivalry, making it particularly useful for examining family systems perspective. The film generates strong responses from most viewers. Available for rent from many universities, including University of Illinois, North Texas State, University of Michigan.

MODULE TITLE: Working with Families of Older Adults

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
A. Family patterns in later life	1. Briefly explain family systems theory and apply it to a specific family.	a. Lecture on family systems theory, illustrated with examples of its application to several families. b. Have participants chart their own families, using the family systems approach. (Alternatively, students may chart the family system of a client well known to them.)
	2. Describe the major family patterns among the older population in terms of marital status, living arrangements, and proximity.	c. Ask participants to identify the marital status, living arrangements, and proximity to other relatives of one of their clients. Compile the demographic characteristics of those clients on a chalkboard or flipchart. Then, using lecture and/or handouts, compare the demographic profile of the clients to that of the older population in general. Discuss any major differences. d. Discuss the accuracy of the common perception that families abandon their elders.
B. Relationships between aging parents and their children.	1. Identify the common emotional themes in relationships between aging parents and their adult children.	a. Have participants generate a list of feelings which aging parents and adult children may have toward each other. Then briefly lecture on common themes, including guilt, dependency, resentment, caring. Note the frequent inverse relationship between "caring about" and "caring for" aging parents.
	2. Discuss the salient dimensions in which the quality of relationships between aging parents and their adult children may vary.	b. In small groups (4-5 members), ask each participant to place a monetary value on what his/her childhood was "worth." Then have them discuss what adult children and aging parents "owe" each other. (Each group should develop two lists - what children owe parents and what parents owe children.) Have the small groups report back to the whole. In discussing

TOPICS	**STUDENT COMPETENCIES: At the end of the module, students should be able to--**	**SUGGESTED PRESENTATION METHODS**
		participants' different responses to the exercise, emphasize the variability of values regarding filial responsibility as well as the variability of other qualitative aspects of family relationships.
	3. Discuss the effects that roles and relationships within the family (e.g., siblings, in-laws, parent-child dyads) may have upon the family systems of older adults.	c. Lecture on family relationships and helping patterns, including: 1) definitions of the terms "filial responsibility" and "filial maturity" and how values vary by social group; 2) research findings on intergenerational helping; 3) the impact of roles and relationships within the family on the family as a whole (e.g., sibling rivalry, special bonds between parent-child dyads, in-law relationships). Also briefly discuss the importance of friends in supporting elders and their families.
		d. Show and discuss the film, "When Parents Grow Old."
C. Assessment of families	1. List the characteristics of the family system which should be included in a comprehensive family assessment.	a. Lecture on the process of assessing families, including: 1) ways to gather information; 2) what to look for; and 3) how extensive an assessment to do.
		b. Have participants generate a list of salient factors to consider in a comprehensive assessment.
	2. Assess the strengths and weaknesses of a specific family as a system and of individuals within that system.	c. Have participants collectively assess a family. (A videotape of a family, the family in the film, "When Parents Grow Old," a case presented by one of the participants, or a case history brought by the instructor may be used.) For further practice, have participants discuss and assess additional cases in small groups, reporting the results to the whole group.

MODULE TITLE: Working with Families of Older Adults

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
	3. Distinguish between the characteristics of healthy and sick family systems. 4. Discuss signs that a family should be referred to other professionals for assistance.	d. Lecture on the distinguishing characteristics of healthy and "sick" family systems. Emphasize that "family health" is actually a continuum. Also discuss when human service workers should refer families with major problems to other professionals. e. Role play a family coming to an agency for an assessment.
D. Working with the family	1. Identify the potential roles of human service workers vis-a-vis the aging family.	a. Discuss the appropriate roles of human service workers with aging families (e.g., support, counseling, compensation). (Possibly include a discussion of facilitative and impeding agency policies which may affect service to families.)
	2. Outline the principles of working with the family.	b. Lecture about the principles of working with families (see Herr and Weakland reference), illustrated with case examples.
	3. Suggest techniques for dealing with difficult family dynamics.	c. In small groups, have participants discuss how they would handle case histories with difficult family situations. (These cases may be suggested by the participants based on their own experiences or selected by the instructor.)
	4. Describe several approaches to involving families in decision-making under normal and crisis conditions.	d. Role play two typical situations facing aging parents and their adult children, one under "normal" circumstances (e.g., gradual changes and/or longstanding problems), the other under "crisis" circumstances. The processing of the role plays should include discussion of how to involve family members appropriately in decision-making.

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
E. Family supports and social services	1. Develop a service plan which balances the emotional and functional needs of the family system.	a. Lecture on the elements of a service plan (brief). b. In small groups, have participants develop a specific service plan based on one of the role playing situations and/or case analyses presented under Topic D.
	2. Locate and explain how to access formal and informal social services.	a. Have participants generate a list of typical social services available for older adults and their families in the community. (This may be supplemented by handouts on actual local services - a local resource directory or materials compiled by the instructor.) Then discuss how, when, and why to refer aging parents and their families to social services and other formal and informal community resources. b. Wrap-up lecture summarizing the main points covered during the workshop. c. Have participants each share one thing they've learned which they plan to apply in their work setting. d. Role play counselor trying to help family negotiate obtaining services from social agency.

ASSESSMENT:

1. The daughter of an older woman feels that her mother should be placed in a nursing home. The mother feels she is capable of taking care of herself. The way you can help resolve this is to:

   a. encourage the daughter to accept the mother's desire to remain living independently.
   b. get a physician's opinion about the mother's ability to care for herself and accept this decision.
   c. accompany them to nursing homes so the mother's anxiety about them will be lessened.
   *d. meet with the client and her daughter together to discuss the situation.

2. An older man is living with his daughter and son-in-law, both of whom work. The daughter is concerned because the father wanders off during the day, becomes confused, and often forgets to take his medication. The best suggestion to give the daughter is to:

   a. consider placing the father in a nursing home where he can be supervised.
   *b. consider placing the father in an adult day care program.
   c. hire a day time homemaker for the father.
   d. ask the neighbors to keep an eye on her father.

3. You suspect that an older client for whom you are providing services is being neglected and/or abused by family members. You should first:

   a. call the police and ask them to investigate.
   b. call an attorney and ask for advice.
   *c. contact protective services or the guardianship agency in your state.
   d. discuss your observations with the family.

4. In identifying the problems of older people, you will most likely find that these clients:

   a. are less able to describe or explain their problems.
   b. tend to exaggerate minor problems.
   c. have the greatest need for family or social support.
   *d. are more likely to have chronic medical problems.

5. A 68-year old woman's husband has just died. She was married to him for 48 years. The biggest problem she will most likely need help with is:

   a. managing her finances.
   b. finding another partner.
   c. keeping busy.
   *d. learning to live alone.

6. In developing supports for older people, the most likely source would be:

    a. church or synagogue
    b. senior citizen's center
    c. friend or neighbor
    *d. son, daughter, or daughter-in-law

7. Decisions about who should care for an older parent are generally guided by all but one of the following:

    a. previously established family relationships
    b. daughters are more likely to become the caretakers than are sons
    c. the child that has the most space in their home
    *d. the child that has the greatest income

8. When assessing the strengths and weaknesses of a family unit it is more important to:

    a. assess the communication patterns of the family
    b. assess the ability of the family to adapt to stressful events
    c. assess the willingness of the family to listen to the concerns of the senior
    d. assess the financial ability of the family to support the needs of the senior

True or False(*)

*9. More than half of all older women are widows.

10. Family members often feel guilty about their relationships with seniors.

*11. All seniors who are unable to care for themselves should have a legally appointed guardian.

12. Not every family member who wants to care for a senior should do so.

13. Churches and neighborhood senior groups are among the informal support services that can assist the senior.

14. Families tend to focus on past competencies of aging parents, making it more difficult to accept the current functioning of their relatives.

*15. Old family patterns and difficulties are easily set aside when an aging parent is in need.

SAMPLE WORKSHOP SCHEDULE

9:00 - 9:10 A.M.	Introduce trainers and participants. Overview of workshop agenda and objectives.
9:10 - 9:30	Lecture on statistical information about family patterns of older adults and on family systems theory. Illustrate systems theory with a case example.
9:30 - 9:45	Small group exercise. Have participants generate two lists: 1) what adult children "owe" aging parents and 2) what aging parents "owe" adult children.
9:45 - 10:10	Compile the small group lists and briefly discuss differences. Then lecture on "filial responsibility," emphasizing individual, religious, ethnic and generational differences in views of filial responsibility.
10:10 - 10:25	Break
10:25 - 10:45	Have group brainstorm common feelings which adult children and aging parents have toward each other, then lecture on common emotional themes in families.
10:45 - 11:45	Show and discuss the film, "When Parents Grow Old." Guide participants through a systematic analysis of the family in the film.
11:45 - 12:00	Lecture on family helping patterns and myth that families abandon their elderly members.
12:00 - 1:00 P.M.	Lunch
1:00 - 1:45	Lecture with case examples on process of family assessment. Then lecture with discussion on human service roles and principles for working with families.
1:45 - 2:30	Role play (in small groups) and process a situation in which a family comes to an agency to discuss possible institutional placement.
2:30 - 2:45	Break
2:45 - 3:00	Discussion of ethical and practical issues involved in family decision-making.
3:00 - 3:15	Lecture on elements of service planning, followed by brainstorming on community resources typically available for elders and their families.
3:15 - 3:45	Have small groups develop service plans for one or two cases, then share their service plans to the whole group.
3:45 - 4:00	Wrap-up and evaluation

WORKSHOP MODULE
Debra David

TOPIC:

Matching Older Clients and Services

SYNOPSIS:

This workshop will cover how to help older adults locate needed resources and services in the community. It will present a problem-solving approach to information and referral services, available services and resources, and methods for handling difficult situations.

RATIONALE:

Negotiating the maze of services available to meet the needs of older people is often a difficult task. Locating the right services in a fragmented system; dealing with bureaucratic jargon, rules, and errors; coordinating services to cope with multiple problems; and knowing where to turn when appropriate services are not available are challenging under the best of circumstances. For a frail elder, outside assistance is often necessary to help them identify and contact the appropriate services.

Human service practitioners in a wide range of positions may play a critical role in matching older clients with services. They need to understand the process of problem-solving with the client, locating needed help, and handling difficult situations (such as lack of services; crises; bureaucratic snafus; demanding or resisting clients). This workshop will present a model of information-giving and referral, an overview of community services, and some methods for dealing with problematic situations.

RESOURCES:

1) Printed materials

Administration on Aging, Information and Referral Services: Information Giving and Referral. Prepared by D. C. Tessari, S. Zimmerman, L. J. Yonce, and N. Long. Washington, D. C.: Government Printing Office, 1974.

> In addition to providing an overview of information and referral (I & R) services, this short book includes useful sections on interviewing techniques, handling emotions, understanding correctly the presenting problem(s), and thoroughly knowing available resources. Case studies supplement the narrative.

Administration on Aging, Program Development Handbook for State and Area Agencies on Information and Referral Services for the Elderly. Prepared by Community Research Applications, Inc. Washington, D. C.: Government Printing Office, 1977.

Covers the delivery of I & R services for older adults, including chapters on their importance, service definitions, models for delivery, aging agency roles, and service provider operations. Slightly dated. Appendices include a brief bibliography, sample training exercises, and a variety of resources for actual service programs.

Holmes, M. D. and D. Holmes, Handbook of Human Services for Older Persons. New York: Human Sciences Press, 1979.

Systematic presentation of eight major types of service programs specifically for older adults (such as multipurpose senior centers, homemaker and home health services, employment services, and I & R programs) covering definitions, funding sources, program models, service issues, and related service delivery concerns. Useful for an instructor who is not directly familiar with aging network services.

Irwin, T., After 65: Resources for Self-Reliance. New York: Public Affairs Pamphlets. (No. 501), 1973.

Consumer booklet that briefly but clearly summarizes a broad range of community and in-home service programs for the aged. Because of its clarity and emphasis on self-reliance, this booklet may be a useful handout for workshop participants, particularly for those who are not already knowledgeable about community resources.

Mathews, R. M. and S. B. Fawcett, Matching Clients and Services: Information and Referral. Beverly Hills, Ca.: Sage Publications, 1981.

This is a basic text on developing and providing generic I & R services, designed primarily for beginning practitioners.

Wolff, A. R. and G. W. Meyer, "Counseling Older Adults: Suggested Approaches," pp. 173 - 194 in M. L. Ganikos (ed.), Counseling the Aged: A Training Syllabus for Educators. Falls Church, Va.: American Personnel and Guidance Association, 1979.

A simulation called"Meet the Bureaucracy" provides a useful way for trainees to practice matching problems with specific agency resources. Self-help approaches are also encouraged. (The rest of this chapter discusses various counseling approaches; not directly relevant to this workshop.)

NOTE: Local and state agencies also develop printed resource materials primarily applicable to their own communities. In Illinois, valuable resources may be obtained through the Illinois Department on Aging ("Services to Older Persons in Illinois: A Handbook for Senior Citizens" and "Information and Referral Handbook") and from Region Two Area Agency on Aging ("Information and Referral: A Guide for I & R Services to Older Persons," developed with Northwest Illinois Area Agency on Aging and Suburban Cook County Area Agency on Aging.) Instructors might wish to seek out similar materials in their own communities. Copies of local resource manuals make particularly helpful handouts for workshop participants.

2) Audio-visual materials and simulations

Tell Me Where to Turn (film)

This older film (19 min.) provides an overview of I & R services and their importance for older adults. Available from North Texas State and Iowa State Universities and other universities.

Working with Older People (simulations, slides and films)

This "resource kit" presents a variety of methods for introducing hard-to-handle service situations for group problem-solving, designed to be used for training practitioners. The printed materials include guidelines for 43 simulations (15 to be used with the films, the remaining 28 role plays, playlets, narratives, and in-basket exercises to be used separately). The audio-visual materials include an orientation slide presentation and 15 film vignettes on 3 reels. The materials may be ordered (separately or together) from the National Center for Research in Vocational Education, National Center Publications, Box F, 1960 Kenny Road, Columbus, Oh., 43210. Also, the audiovisual components may be available for loan from your State Office on Aging. Topics most closely related to this workshop include: "coping with bureaucracy," "acknowledging agency or personnel restrictions," and "recognizing an emergency."

MODULE TITLE:

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
A. Understanding the older client	1. Discuss the special service needs of older clients.	a. Briefly present the importance of information and referral services (I & R) for older adults, then preview the workshop objectives and agenda.
		b. Have participants introduce themselves, identifying their agencies, work roles, and their reasons for attending the workshop.
		c. In small groups (4 to 6 members), have participants identify at least 3 ways in which older clients have special service needs. Also, have them identify at least 3 problems group members have had in helping older clients obtain specific services and 3 types of situations which group members find difficult to handle. In the whole group, pool the lists on a board or flipchart. (You may also wish to have the whole group rank the problems according to which ones they would most like to discuss.) The list of service needs of older clients can form the basis for method below; the list of problems obtaining specific services can be used for problem-solving practice under topic B; and the list of difficult situations can be used for cases/role plays under topic D.
	2. List common problems which human service workers face in helping older clients obtain needed services.	d. Summary lecture about the service needs of older clients and common problems which workers face in matching clients and services.
B. A problem-solving model to I & R	1. Outline the steps of problem solving and illustrate the application of those steps to a specific service problem.	a. Lecture with handout outlining the steps of problem-solving. (Any relatively simple model familiar to the instructor can be used. A typical model is: 1) define the problem thoroughly; 2) identify the criteria which any solution

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
		must meet; 3) brainstorm possible solutions; 4) select the best solution; 5) evaluate the results and make needed changes, on a careful analysis of the problem and consideration of all possible solutions.) Illustrate the application of the problem-solving model to two or three typical situations likely to be faced by a human service worker. b. Have each student select a problem related to matching older clients and services and individually write down how they might handle it according to the problem-solving model. Then have them discuss their solutions in small groups (3 or 4 members). c. Present and discuss several situations which relate to involving the client in the decisions-making process, such as: 1) when a client specifically asks the worker to give advice or make a decision; 2) when a family member calls for a service on behalf of a relative; 3) when the worker is uncomfortable with the decision of a mentally competent client; and 4) when the worker questions the mental competence of the client. Emphasize the importance of client self-determination. d. Role play several typical situations involving matching clients with services. Several participants may take turns playing the role of the "worker" in problem-solving a moderately complex problem. e. Have participants brainstorm about signs that a client needs assistance with carrying out a referral.

MODULE TITLE: MATCHING OLDER CLIENTS AND SERVICES

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
C. Community services and other resources	1. Identify and locate the major types of services and resources for older clients available in the community.	a. Lecture on sources of assistance for older people, covering: statistics on who elders turn to for help; conditions under which they are likely to turn to formal services; and ways to coordinate formal services with informal supports.
	2. Discuss ways to tap the older client's existing informal support network and non-traditional sources of help to meet their needs.	b. Have participants map their own informal support systems. They should then consider: 1) to whom they would turn in case of various types of crises (financial, health, emotional, etc.); 2) to whom they would turn if their primary source of help were to be removed. Discuss their responses, emphasizing the importance of informal supports as sources of services.
		c. Have trainees generate a list of types of services and other resources in the community, including: 1) age-based services; 2) need-based services; and 3) non-traditional resources (e.g., churches, postal carriers, service clubs, businesspeople).
		d. Demonstrate the use of a resource manual; circulate the manual for participants to examine. Then have them brainstorm about resources which may not be included in the manual (e.g., clubs, neighbors, self-help groups).
	3. Suggest several strategies for coping effectively with bureaucracies which provide services for older clients.	e. Play the simulation "Meeting the Bureaucracy" described in the Wolff and Meyer reference. (Basically, this involves some participants representing community agencies, while others are given lists of problems which they must "solve" by identifying the proper agencies or generating self-help solutions.)

MODULE TITLE: MATCHING OLDER CLIENTS AND SERVICES

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
		f. Lecture/discussion on how to work as an effective advocate on behalf of clients who run into problems obtaining needed services from public and community-based agencies.
D. Handling challenging situations	1. Recognize crisis situations and outline the steps of crisis intervention.	a. Lecture on recognizing crisis situations, with a brief introduction to the steps of crisis intervention. b. Have trainees analyze several brief case presentations to determine: 1) whether a crisis exists; and 2) if so, what they would do.
	2. Demonstrate an ability to deal with "difficult" (e.g., angry, demanding, uncooperative) clients.	c. A number of films, role plays, and simulations in "Working with Older People: a Resource Kit" deal with challenging situations which may arise in trying to help elders obtain needed services. See in particular numbers 2, 7, 16, 20, 23, 28, 29, 32, and 43.
	3. Suggest ways to handle situations in which no appropriate service is available.	d. In small groups, have participants develop ways to deal with case examples (either through discussion or role plays), then report their solutions to the whole group. e. Wrap-up lecture summarizing the main points of the workshop.

ASSESSMENT

1. *True False Approximately 80% of all services received by older people are provided by their relatives.

2. True *False If you cannot match a client with an appropriate service, there is no need to record your contact.

3. *True False If ordered by a physician, Medicare will pay for home health services.

4. True *False If ordered by a physician, Medicare will pay for intermediate care in a nursing home.

5. True *False If a client is reluctant to use the services of an agency, you should contact the agency on the client's behalf.

6. The first step in problem-solving is to:

   *a. clearly define the problem.
   b. list all the existing services which may be appropriate.
   c. reassure the client that the problem can be resolved.
   d. determine what solutions the client has already tried.

7. If a needed service is not available, the best action is to:

   a. refer the client to an agency which provides a related service.
   b. apologize to the client and acknowledge your limitations.
   *c. consider alternative ways to handle the problem.
   d. refer the client to the local area agency on aging.

8. Which of the following will pay for extended nursing home care if the client is eligible?

   a. Blue Cross
   b. SSI
   c. Medicare
   *d. Medicaid

9. An appropriate way to deal with a client who refuses to accept needed services because he/she feels that the services are "charity" is to:

   a. tell the client that you would definitely accept the service in similar circumstances.
   b. make an appointment on the client's behalf and encourage the client to keep it.
   c. point out how the client has "earned" the help through years of contribution to society.
   *d. explain the service briefly and offer to assist the client if he/she decides to apply.

10. The daughter of an elderly woman seeks help for her mother who is increasingly confused. The most appropriate referral would be to:

- *a. a physician or medical clinic.
- b. a community mental health center.
- c. a family service agency.
- d. an adult day care program.

11. If a client had his/her food stamps reduced or cut off, the most appropriate response is to:

- a. call the public aid office to ask the caseworker the reason for the referral.
- *b. refer the client to a legal service or advocacy program for help in filing an appeal.
- c. help the client figure out a new budget to deal with the financial change.
- d. refer the client to a nutrition site for inexpensive meals.

12. In working with a hearing-impaired elder, it's a good idea to:

- a. speak very loudly in low tones.
- b. communicate through a third person who knows the elder.
- c. repeat yourself and use simple words.
- *d. speak clearly and face the elder directly.

13. Need entitlement programs include all of the following except:

- a. Food stamps
- b. Energy assistance
- *c. Nutrition sites
- d. SSI

14. Older clients are more likely than younger ones to:

- *a. have multiple service needs.
- b. be pleasant, cooperative clients.
- c. have difficulty describing their problems.
- d. have friends or relatives who are willing to help them.

SAMPLE WORKSHOP SCHEDULE

9:00 to 9:15 A.M.	Introductions. Have participants share their names, agencies, and why they are interested in the topic.
9:15 to 9:20	Overview of the day's objectives and agenda.
9:20 to 9:30	Lecture on the special service needs of older clients.
9:30 to 9:40	Buzz groups of four or five members to identify problems which participants have experienced in trying to meet service needs of older clients. Problems should include difficulties involved in locating appropriate concrete services and more general problems in dealing with challenging situations.
9:40 to 9:50	Whole group sharing and ranking of problems lists of buzz groups, divided into concrete service problems and challenging situations.
9:50 to 10:00	Lecture with overhead and/or handout on the steps of problem-solving.
10:00 to 10:15	Illustration of problem-solving with a specific problem (probably housing).
10:15 to 10:30	Have pairs of participants select one problem from the list of concrete service problems to work through together. One should represent the human service worker's perspective, the other the client's perspective. Trainers consult as needed.
10:30 to 10:45	Break
10:45 to 11:00	Process the problem-solving practice, having pairs discuss what went smoothly and what did not.
11:00 to 11:15	Have buzz groups brainstorm for five minutes on different types of services available in a typical community which might be used by older clients. (Assign a different type to different buzz groups, though more than one buzz group might be assigned to a type.) Include: age-entitlement programs; need-entitlement programs; age- and need-entitlement programs; general service programs without age/need restrictions; and self-help and advocacy groups. Then have the groups share their lists, fill in each others lists.
11:15 to 11:25	Discussion. What do you need to know about a service to really be able to help a client?
11:25 to 11:35	Brainstorming on information sources helpful to service providers. Also distribute or circulate resource manuals and directories.

11:35 to 11:50	Lecture on referral procedures and some guidelines for effective advocacy with bureaucracies and other agencies.
11:50 to 1:00 P.M.	Lunch
1:00 to 1:20	Have participants identify their own support networks (i.e., to whom they would turn for help in various situations). Then lecture briefly on working with informal supports of older clients (family, friends, neighbors, church, etc.).
1:20 to 1:30	Introduce the simulation, "Meeting the Bureaucracy."
1:30 to 1:45	Play round one of the simulation.
1:45 to 2:00	Switch roles and play round two of the simulation.
2:00 to 2:15	Process the simulation.
2:15 to 2:30	Break
2:30 to 2:40	Lecture introducing the topic of challenging situations.
2:40 to 2:55	Role play in groups of 3 or 4 a difficult situation (selected from the list generated by the group in the morning or a situation in which the appropriate service is not available.)
2:55 to 3:00	Whole group discussion of role play.
3:00 to 3:15	Role play in same groups a second situation (selected again from the list generated by the group or a situation in which two family members have conflicting needs).
3:15 to 3:20	Whole group discussion of role play.
3:20 to 3:25	Show "Working with Older People" film situation 7 (dealing with an emergency situation) or 2 (dealing with a refusal of service to a poor client).
3:25 to 3:35	Discussion of film in small groups (perhaps combining two role playing groups).
3:35 to 3:50	Wrap-up lecture, summarizing key points about dealing with challenging situations and reviewing the workshop objectives.
3:50 to 4:00	Assessment of participant learning and evaluation of workshop.

WORKSHOP MODULE

Peggye Dilworth-Anderson, Ph.D.

TOPIC:

Reaching the Minority Elderly

SYNOPSIS:

Defining and describing the minority elderly in reference to developing ethnic sensitive service delivery strategies and outreach approaches are covered in this workshop. Other major focuses include developing sensitivity to cultural variations among the diverse minority elderly population and how these groups themselves can and should have input in structuring a viable service delivery system.

RATIONALE:

The term minority is defined in many ways; here it refers to members in a society who have been singled out for differential and inferior treatment on the basis of such characteristics as their race, sex, nationality or language. Although there is an emerging literature on the minority elderly, very little information is available that would facilitate understanding what services to provide them. Also, very little is known about the influence of their cultural identity on the utilization of services. Therefore, the purpose of this workshop is to make available information on defining and describing the minority elderly. Further, it provides practitioners the opportunity to better understand ethnic-sensitive approaches and strategies that can be used to better assure relevant and meaningful service delivery.

Service providers can address the needs of minority elderly people in relation to their ethnic identity, as well as to being elderly. They can also help clients develop self determination in regard to accepting and utilizing the service delivery system. Overall, the sensitivity, knowledge and skills practitioners can gain from attending this workshop can enhance their ability to better serve the minority elderly.

RESOURCES:

1) Printed materials

Gartner, Alan and Frank Riessman, "New training for new services," Social Work, Vol. 17, No. 6, November, 1972.

> The authors present suggestions for training and retraining practitioners to work with diverse groups of clients with different racial and cultural backgrounds.

Gelfand, Donald and Alfred Kutzik (ed.), Ethnicity and Aging. New York, N.Y.: Springer Publishing Co., 1979.

> The contributors to this book provide a broad interdisciplinary scope to understanding the meaning and impact one's ethnic identity has on the aging process. Very useful background information for instructor; too difficult for participants.

1) Printed materials (cont.')

Jackson, Jacqueline, Minorities and Aging. Belmont, Ca.: Wadsworth Publishing Co., 1980.

Jackson introduces the reader to many demographic characterisitics of minority aged people. She also includes discussions on the psychological and social conditions of the elderly that influence their quality of life. This book is a good resource for instructor and participants to use.

Mizio, Emelicia, and Anita Delany (ed.), Training for Service Delivery to Minority Clients, N.Y.: Family Service Association of America, 1981.

Every chapter in this book provides insight into how to address minority clients. The authors discuss many substantive and theoretical issues relevant to preparing a practitioner to work with minority clients. Many inferences can be made to older clients as well as those that are younger from the discussions. Very instructive book for participants.

Pinderhughes, Elaine, "Teaching empathy in cross-cultural social work." Social Work, Vol. 24, No. 4, July, 1979, pp. 312-316.

A very informative discussion to help practitioners learn to develop sensitivity to the values, norms, beliefs and expectations of different racial/cultural groups.

Trader, Harriet, "Survival strategies for oppressed minorities," Social Work, Vol. 22, No. 1, January, 1977.

U. S. Commission on Civil Rights, Minority Elderly Services - New Problems, Old Problems, Part I and II. Washington, D. C.: U. S. Commission on Civil Rights, 1982.

This two part series describes programs now available to minority older people in different sections of the U. S. Information is provided on the level of utilization of services. These books could be of assistance to the instructor in preparing for this workshop.

Wynette, Devore and Elfriede Schlesinger, Ethnic Sensitive Social Work Practice. St. Louis, Mo.: The C. V. Mosby Co., 1981.

A very informative book that methodically outlines different approaches practitioners use to address the needs of their clients. The authors examine to what extent each approach is relevant to addressing the problems of ethnic and racial groups.

The author introduces a theoretical model that emphasizes the practitioner and client learning from one another which can help minority people receive more relevant and useful services.

2) Audio-visual materials

The Invisible Minority
22 min./color/1977/16mm film

Black and Mexican-American elderly, two groups often invisible to the larger society, are the focus of this documentary set in the Los Angeles area. Actual visits with these persons point up some of the problems they encounter in a large urban setting: crime, transportation, and loneliness. The film also explores some of the resources upon which older persons draw. It suggests that recently developed community programs provide new sources of support for many older minority persons, but that these programs have only begun to address the problems.

Rental: University of Southern California
Film Distribution Center
Division of Cinema
University Park
Los Angeles, Ca. 90007
(213) 741-2238

Beyond Language
23 min./color/1979/Filmstrip/Audiocassette (in a series)

Presents aspects of communication - both verbal and nonverbal that go beyond vocabulary, grammar, and verbal facility. Also, aspects such as gestures, experssions, and communication styles are explained. Gives specific guidelines for communicating with Asian, Hispanic, Black and Native Americans.

Purchase only: Concept Media
P.O. Box
Irvine, Ca. 92714
(714) 833-3327

Old, Black and Alive
28 min./color/1974/16mm film

Contrasts the lives and thoughts of several elderly blacks of varying backgrounds. In nursing homes, in their own homes or still in working situations, these elderly provide an intimate profile of their feelings about being old. As well as personal and social insights, the film reveals a strong religious element that is for some of them a source of hope. What emerges is the sense that these people are living each day with a wisdom and strength that enables them to overcome the physical and psychological realities of aging. Designed to stimulate dialogues on aging, death and dying, black social problems and religion.

Sales/Rental: New Film Company
331 Newbury St.
Boston, Ma. 02115
(617) 261-3046

MODULE TITLE: Reaching the Minority Elderly

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
A. Who are the minority elderly?	1. Discuss the different ways the term minority is defined. Understand how the definition of a group ultimately affects one's perception of its problems and needs. 2. Discuss the definitions professionals and paraprofessionals often use to define a minority group. Understand how overall quality of life is affected by minority group status in general and particularly during the later years.	a. Allow each participant to give her own definition of what people she considers to be the minority elderly. Also encourage participants to give some comments on how they arrived at a definition. b. Lecture/discussion on defining minority groups. Provide information on the social, psychological and economic ramifications of the "double jeopardy" position of minority elderly in American society. c. Provide printed tables describing the demographic characteristics of elderly Blacks, Puerto Ricans, Mexican-Americans and Native Americans. (See U.S. Census Data.) Other ethnic groups indigenous to the workshop location should be included as well. d. Film - The Invisible Minority

MODULE TITLE: Reaching the Minority Elderly

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
B. Strategies to help encourage ethnic-sensitive service delivery.	1. Explain how understanding one's own perceptions of minority people can affect sensitivity to approaches used in service delivery to them. 2. Identify common problems and concerns of service providers in working with minority elders. 3. List the most useful and ethnically sensitive service delivery approaches that can be used to address the needs of the minority elderly.	a. Lecture/discussion on developing ethnic-sensitive service delivery in relation to: 1) assessment of one's own perceptions about the minority elderly; 2) dispelling common stereotypes and myths about minority elderly and 3) learning how to integrate one's own or agency's approach to service dleivery with what the client may indicate as being most useful. b. Lecture/discussion on different conceptual frameworks used in human service delivery which influence how effectively the needs of the minority are met. Emphasize the extent to which a particular theory also fits the needs of the minority group to which an agency directs its practice. c. In small groups, have participants identify problems and concerns they have related to serving minority elders. Compile the identified problems and concerns in the whole group. Results could be used as basis for method d. d. Simulation/role playing involving "taking the role of the other" would include participants interchangeably assuming the role of client and service provider. This simulation would be followed by the instructor leading a discussion on the implications of understanding how to communicate with minority clients. e. Film - Beyond Language

MODULE TITLE: Reaching the Minority Elderly

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
C. Outreach approaches to enhance service delivery to the minority elderly.	1. Identify the most effective approaches that should be used to both locate and inform the minority elderly of available services. 2. Understand what characteristics among the different groups of minority elderly influence outreach strategies designed to enhance service delivery. 3. Develop sensitivity to particular characteristics among the minority elderly that influence how well one will be able to identify, understand and address their needs.	a. Divide participants into 2-3 groups to develop a list of effective traditional and non-traditional ways to locate and inform the minority elderly of services that are available to meet their needs. Then discuss the most effective approaches each group listed. This list should coincide with the instructor's understanding of the appropriate strategies that could be used. b. Invite a social or behavioral scientist to discuss cultural, racial and ethnic similarities and differences among the minority elderly that influence service delivery to them. This discussion sould also focus on how the elderly compare to the elderly population in general in regard to how minority group status influences utilization of services. c. Lecture on service and demonstration programs which have been successful with minority elders.

MODULE TITLE: Reaching the Minority Elderly

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
D. Empowering the minority elderly client	1. Understand why the elderly in general, especially the minority elderly, should have some input in deciding the types of services they are offered and the manner in which they are provided.	a. Provide handouts with a discussion on ways to help clients develop self-determination and a sense of empowerment. b. Invite local service agency representative(s) to discuss their agency strategies for serving minority elders and problems which they encounter. c. Summary lecture that integrates the major topics so that participants can better: 1) define, 2) describe, 3) become sensitive to, and 4) understand cultural identity of the minority elderly. This summary also needs to include outlining strategies for participants to understand how to Help clients develop more self determination or power in relation to the human service delivery system.

WORKSHOP SCHEDULE

A.M.

9:00 - 9:15	Introduction of instructors and participants
9:15 - 9:30	Overview of the day's agenda and workshop objectives
9:30 - 10:00	Each participant expresses his/her own ideas on what people he/she considers to be the minority elderly. Discussions on how experiences and information affect views on defining the minority aged.
10:00 - 10:30	Lecture/discussion on defining the minority elderly. Provide printed materials on demographic characteristics, follow with explanations of data.
10:30 - 10:40	Break
10:40 - 11:10	Film - The Invisible Elderly
11:10 - 11:20	Reaction to film
11:20 - 11:45	Lecture/discussion on developing ethnic-sensitive services to minority elderly.

P.M.

11:45 - 12:45	Lunch
12:45 - 1:05	Lecture/discussion on different conceptual frameworks used by an agency or practitioner that affect service delivery.
1:05 - 1:30	Simulation - "Taking the role of the other."
1:30 - 2:00	Film - Beyond Language
2:00 - 2:10	Break
2:10 - 2:30	Divide participants into small groups to develop strategies to locate and inform clients of services.
2:30 - 2:45	Reconvene groups to discuss and list most effective outreach strategies developed by small groups.
2:45 - 3:05	Lecture on comparing similarities and differences among minority people that affect utilization of services.
3:05 - 3:15	Question/answer time regarding lecture.
3:15 - 3:30	Provide handouts, follow with short discussion on ways to help clients develop self-determination.
3:30 - 3:50	Summary lecture and wrap up of the day's activities
3:50 - 4:00	Evaluation

EVALUATION

Please circle the correct answer.

1. T *F The term minority is defined the same way by most people.

2. *T F The concept of double jeopardy refers to discrimination in relation to to both age and race.

3. *T F Older minority women are considered the poorest of the elderly in the U.S.

4. *T F The transactional teaching-learning approach to service delivery used by social providers involves both the client and practitioner working together.

5. *T F A systems approach to service delivery involves the practitioner serving as a mediator for client in relation to the many things that affect their lives.

6. *T F The concept "empowerment" means that clients learn and exercise their rights to determine how the social system addresses their needs.

7. *T F Most minorities underutilize social services.

8. *T F Research findings show that elderly minorities more often than whites receive support from family members.

9. *T F About twice as many blacks and other minorities as compared to whites are illiterate.

10. *T F Ethnic-sensitive service delivery involves the practitioner having a keen sensitivity of matters of concern to members of minority groups.

11. *T F The place of worship is one of the most significant places to reach minority elderly people.

12. *T F Services to the elderly minority can be better planned by communicating with family members.

WORKSHOP MODULE
Mich Barbezat

TOPIC:

Dealing with Death

SYNOPSIS:

This module will help persons understand death and its effects on the dying and the family. Suggestions on helping the dying and the family to cope more effectively with the situation will be discussed.

RATIONALE:

It is impossible to deal with the elderly without encountering dying or grief and bereavement. The human service worker can, indeed must, give supportive and meaningful guidance to the dying and those who love them.

Many factors in our culture tend to hide the fact of death and this can make coping with the situation more difficult. It is therefore important, that the direct service provider understand the cultural context in which death occurs and its effects on the dying and the family. The individual and the context will affect the response to the process itself and the grief and mourning such an event causes. When the significance of the above is understood a service provider can better assist death's negative effects and in many cases alleviate many of its destructive effects and replace them with a sense of meaning. Death, in this sense can become the last creative step of life. Meaning, communication and self-esteem can often be preserved till death occurs. With such a belief a worker can help the dying and the family to understand what needs to be done and to keep open channels of communication. Death can then be dealt with creatively and honestly.

In order to be able to fulfill this, service providers need to face their own beliefs and ideas about dying. Some time will therefore be devoted to this task at the beginning of the module.

Direct service providers will benefit from knowledge about dealing with death in almost all settings that deal with the elderly. It is also helpful to anyone in the helping professions.

RESOURCES:

1) Printed Material

Berrigan, Daniel., We Die Before We Live: Talking to the Very Ill. New York: Seabury Press, 1980.

> Berrigan is a poet and a priest and some regard him as a protestor. In this book about life at a Hospice for the dying he brings these talents to bear. He gives reality to the place and the people who work and die there. The characters he describes make vivid the reality of death and that it can become triumphant.

Eddy, James M. and Alles Wesley, Death Education. St. Louis: The C. V. Mosby Co., 1983.

Eddy and Wesley provide excellent material on the evolution of death education in the United States. They also discuss educational modalities, summaries of research data, and the development of tests and courses in this area. Chapters also deal with bereavement, euthanasia, consumer aspects and suicide. An appendix contains a great amount of information for any educator in this field. An extensive annotated bibliography is also provided. This book is a highly recommended resource.

Horan, Dennis J. and David Mall, eds. Death, Dying and Euthanasia. Washington, D.C.: University Publication of America, Inc., 1977.

This book consists of a collection of views on the definition of death, euthanasia, and the right to refuse treatment. It should be of value to those interested in such topics from a legal, ethical, and religious point of view. Such topics are specially pertinent in dealing with the elderly.

Kubler-Ross, Elisabeth, Questions and Answers on Death and Dying. New York: MacMillan Publishing Company, Inc., 1974.

This book is an attempt to answer some of the most frequently asked questions posed by audiences at the many workshops, lectures, and seminars conducted by Kubler-Ross. It is very practical in content and deals almost exclusively with the adult patient. It deals briefly with answers to almost every aspect of dying as well as family problems after death has occurred,funerals, staff problems, old age, and dealing with personal questions. Anyone working with the dying can benefit from reading this book. What Kubler-Ross said in 1974 is still applicable today.

Kubler-Ross, Elisabeth, ed. Death, the Final Stage of Growth. Englewood-Cliffs, N.J.: Prentice Hall, Inc., 1975.

Kubler-Ross has gathered a spectrum of views on the subject of death in this book. These views should help the reader develop ideas on the meaning of life and death. It should also help the reader to better deal with his/her own life and death and thus to become a better service provider. Reading this book can be a growth experience.

Kutscher, Austin H.,"Anticipatory Grief, Death, and Bereavement: A Continuum." In Wyschograd, E., ed., The Phenomenon of Death: Faces of Mortality. New York: Harper and Row Publishers, Inc., 1973, pp. 40-53.

Kutscher believes that the losses experienced in life prepare us for the greater loss of a loved one or the individual's own death. He stresses that these can be minor or major preparations for dealing with death. Such insight can be helpful in dealing with the dying. The stages of anticipatory grief and the symptoms of grief are also discussed.

Simpson, Michael, The Fact of Death: A Complete Guide for Being Prepared. Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1979.

Simpson discusses the definitions of death, living with your own death and other often found topics such as grief, suicide, euthanasia, loss and bereavement. The chapter on death is excellent. It deals with such practical matters as funeral arrangements, guidelines to follow when making a will, and a family planning guide.

Weismann, Avery D., On Dying and Denying: A Psychiatric Study of Terminality. New York: Behavioral Publications, 1972.

Weismann presents practical and philosophic guidance for promoting a dignified and appropriate death. Clinical illlustrations are used to document his findings. This book should enhance an individual's knowledge and accommodation to death.

Worden, J. William, Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner. New York: Spring Publishing Co., 1982.

Worden deals with the topic in a readable, practical and succinct way. He deals with normal grief reactions, grief counseling, and abnormal grief reactions. Grieving as it relates to special types of losses is also discussed. A very practical and useful book.

2) Audiovisuals

As Long as There is Life

This film deal with the way a Hospice helps a wife and mother to die at home. It shows the support systems given to the family to help them cope. Excellent for stimulating discussion regarding the needs of the dying and the family. A documentary.

Death and Dying, filmstrip series, Concept Media, 1972.

This series is written from a medical point of view but can be useful to any direct service provider. It deals with the difficulties of nurses in dealing with the dying patient and the feelings of the dying. An excellent filmstrip with wide appeal deals with the American attitude toward death and dying.

Dying, videotape, Public Broadcasting Corporation, 1976.

This is a very powerful documentary. It deals with the lives of four dying persons and that of their families. Each reacts differently to the event. Excellent for promoting discussion.

Make Today Count, Kelley Orville, Media Marketing, 1975. (film)

This film produces a clear picture of a man facing death. It was filmed in the last year of Kelley's life. It covers his speaking engagements as well as his concern over his family. It gives a realistic awareness of a man living with a life-threatening disease.

Whose Life Is It Anyway? film,Raintree Studio, 1978.

This is a controversial film that deals with a quadriplegic and his effort to die with dignity. He battles the medical establishment in his efforts. Promotes good discussion on the subject of passive euthanasia.

NOTE TO INSTRUCTORS

Typically, a great deal of latent emotion is experienced by some participants in such an instructional situation. The leader needs to be sensitive to the needs of participants.

Dealing with participants' feelings is an important starting point. At the outset the sensitive nature of the topic should be explained. Parameters ought to be explained. For instance, it might be pointed out that it is all right to feel emotional and even to cry a little. Any participant should have the right not to deal with a topic if it creates an undue burden on him or her. Participants should be assured of the right to leave the group for a while if the need is felt. A climate of "togetherness" should be created at the beginning of the session. The participants might be asked why they chose the seminar and what they hope to get out of it at the beginning. Enhancing group participation will create a more open climate and each participant will not have to struggle with each concept presented as if it were a personal challenge.

More material is presented than can be used in one session. It is important that the instructor select material suited to the participants. Appendix A, for instance, is less threatening than Appendix B. Depending on the group's familiarity with the subject an appropriate selection can be made. Suicide and euthanasia should only be included with participants who have an awareness and experience with the dying and their families and desire added experience. Furthermore, the instructor should only select materials with which s/he feels comfortable.

Audio-visuals should be kept to a minimum. Use them only as necessary. The video-tape "Dying" contains four episodes. This might be too much for some participants to endure. If it is used, only one case might be presented.

Some instructors feel more comfortable by structuring the seminar going from emotive to cognitive materials as it progresses. Others blend the two. Each method can be effective depending on the leadership. Choose a method that you as instructor feel comfortable with. Be sensitive and alert throughout the session and reduce anxiety as necessary.

MODULE TITLE: DEALING WITH DEATH

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
A. Understanding death and the cultural context	1. Demonstrate an awareness of his/her pattern of dealing with loss.	a. Lecture/discussion b. Have participants fill in questionnaires A, B, or C and discuss the answers in small groups (see appendices)
	2. List 5 ideas persons may hold as to what death is and 4 ways people describe what it is like.	Discuss ways of viewing and describing death in small groups. Process the results with the whole class listing the views and descriptions on a chalkboard.
	3. Fully describe the ways in which people face and evade the fact of death in American culture.	a. Brainstorm views on acceptance and denial. List results on a chalkboard. b. Show filmstrip on American attitude toward death and dying. Discuss. c. In a lecture deal with the fact that denial and acceptance (emotional and intellectual) are not clear cut concepts. The concept of meaning must be considered. In small groups discuss when each might be harmful or useful.
B. The dying process	1. List and explain the 5 stages of dying as outlined by Kubler-Ross	a. Lecture/discussion b. Emphasis should be placed on patient behavior and family response.
	2. Demonstrate an awareness of the difficulty in defining death	Lecture/discussion
	3. Explain and list the different concepts of death over the life span.	a. Lecture b. Sharing of views by participants. c. Questionnaire D can be helpful, especially if students vary in age.

MODULE TITLE: DEALING WITH DEATH

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
	4. Explain the different reactions to death. Show an understanding of the context, the personality, and the circumstances, e.g., sudden death vs. expected death, suicide vs. normal death, child death vs. older adult	a. Show videotape "Dying" and discuss. b. List (see appendix E) types and causes of death and discuss in small groups. Discuss results with total group. c. Lecture/discussion d. Show selected filmstrips of series on death - discuss each
	5. List 8 misconceptions about death	Lecture/discussion (see appendix F for suggestions)
	6. Fully explain views of suicide and euthanasia.	a. Show film, "Whose Life Is It Anyway?" Discuss. b. Divide class in two teams based on real beliefs and debate the issue. Debate suicide and euthanasia separately.
	7. Describe ways of predicting suicide potential	Lecture/discussion
	8. List and describe ego-coping mechanisms on 4 levels	Lecture/discussion (see appendix G)
C. Grief and mourning	1. List the normal stages of mourning	Lecture/discussion
	2. List the roles of bereavement	a. Lecture/discussion b. Have participants share meaningful events or hopes about bereavement.
	3. Demonstrate an awareness of normal and pathological grief and mourning	a. Case studies b. Role play c. Discussion

MODULE TITLE: DEALING WITH DEATH

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
D. Helping the dying and their families	1. Demonstrate the ability to deal with the stages of dying	a. Role play b. List some thoughts you might have if you had a terminal illness or were about to lose a loved one. In dyads discuss these thoughts and how to deal with them. c. Leader takes participants through an awareness raising exercise (see appendix H). Discuss feelings and how best to deal with them. d. Divide participants into two groups, helpers and the dying. Now have helpers tell or not tell depending on response that the dying have a terminal illness.
	2. Demonstrate an awareness of the many reactions family members might experience over the death of a family member or a loved one.	a. Discussion b. Discuss reactions to various responses depending on the context, e.g., unconfirmed death, suicide, death after a prolonged illness, etc. c. Role play dealing with the above.
	3. Describe the difficulties a widow or widower can expect to encounter.	a. Lecture/discussion b. Show filmstrips,"The Widow (2) and the Widower." Discuss.
	4. Show an awareness of the value of dying in a hospital, a hospice or at home.	a. Debate the issue. b. Prepare a list of possible values each has over the other. Include how a decision might be reached in making the choice.

MODULE TITLE:

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
	5. Explain how to help a dying patient who wants to die at home. List 5 major steps the family will have to be aware of in advance.	a. Lecture/discussion b. Show film and discuss.

ASSESSMENT:

Understanding Death and Cultural Context

1. The cyclical view of death is associated most strongly with:

   *a. Buddhism
   b. Judaism
   c. Christianity
   d. Islam

2. The study of death is called:

   a. euthanasia
   b. pathology
   *c. thanatology
   d. deathology

3. Many scientists are beginning to define the parameters of death in terms of:

   a. lack of reflex action
   *b. cessation of brain waves
   c. cessation of cardiac function
   d. lack of pulmonary functions

4. Many believe that in America the reality of death is largely:

   a. accepted
   b. exploited
   c. made too significant
   *d. denied

5. Cryogenics is:

   a. an embalming process
   b. widely used in the U.S.
   *c. a freezing process
   d. an inexpensive way of disposing of a body

6. When discussion the possibility of their own death, most people feel their death will be the result of

   a. cancer
   b. natural causes - old age
   c. heart failure
   *d. accident

7. Approximately what percentage of Americans make a will prior to their death?

   a. 5%
   *b. 25%
   c. 50%
   d. 80%

8. Which religious group allows the greatest variation in funeral ceremonies?

   *a. Protestant
   b. Catholic
   c. Mormon
   d. Jewish

9. Removing the life-support systems of a terminally ill patient is called:

   a. active euthanasia
   b. genocide
   *c. passive euthanasia
   d. thanacide

10. In the U.S., disposal of the body by cremation is used in what percent of total deaths?

   *a. 5 - 15%
   b. 20 - 25%
   c. 40 - 45%
   d. more than 45%

11. Cremation is an ancient custom dating from:

   *a. prehistoric times
   b. 300 B.C.
   c. the Roman Empire
   d. the late 13th century

12. What percentage of the American population is over 65 years of age?

   a. 3%
   *b. 10%
   c. 15%
   d. 20%

The Dying Process

1. Research with dying patients has shown that:

   a. They are not aware of their condition.
   b. They receive more attention from nurses and doctors than regular patients.
   *c. They receive less attention from nurses and doctors than regular patients.
   d. There is no difference in the way terminal and non-terminal patients are treated.

2. Research tends to indicate that the older person's fear of death is:

   a. greater than that of the remainder of the population
   *b. less than that of the remainder of the population
   c. approximately the same as that of the remainder of the population

3. In which stage of Kubler-Ross' stages of dying is the dying person likely to seek other professional and non-professional opinion?

   *a. denial
   b. anger
   c. bargaining
   d. depression

4. Which of the following is not a treatment goal for the terminally ill?

   a. remission of symptoms
   b. pain control
   d. security
   *d. give false hope

5. The best way of relating to a dying person:

   a. is to follow a specific agenda
   b. is to feel helpless
   c. is to extend deep sympathy
   *d. may differ from person to person

6. The Hospice movement was founded by:

   a. Florence Nightingale
   *b. Cicely Saunders
   c. John Christopher
   d. none of the above

7. Suicide potential can be predicted by considering, among other things, all but one of the following:

   a. depression
   b. putting affairs in order
   *c. denying the fact
   d. drastic changes in life-style

8. When a terminal patient expresses feelings of depression he/she should be:

   *a. allowed to express the sorrow
   b. cheered up
   c. told firmly he/she should rather think about good things
   d. none of the above

9. The majority of terminally ill persons:

   a. don't want to talk about it
   b. are better off if they deny the fact
   *c. are afraid to die alone
   d. all of the above

10. When a dying patient has reached the stage of acceptance:

   - *a. little talk may be required
   - b. they regain an interest in news of the outside world
   - c. they are seldom pensive
   - d. all of the above

Grief and Mourning

1. A sign that grief is being resolved is:

   - a. leaving the deceased person's belongings where they are
   - b. refusing to seek professional help
   - c. not crying at all
   - *d. reduced obsessional review

2. After the death of a wife, the widower generally:

   - a. stays a widower
   - *b. remarries within 1 or 2 years
   - c. marries an older woman
   - d. marries a woman he has just met

3. People who appear to be in the greatest need of grief therapy are the survivors of victims who died of:

   - *a. an accident
   - b. cancer
   - c. heart condition
   - d. natural causes in old age

4. The phenomenon of the bereavement process that occurs in the spouse of a terminally ill person prior to the event of death is:

   - a. grief therapy
   - *b. anticipatory grief
   - c. preparatory mourning
   - d. pre-bereavement work

5. A sign of pathological grief is:

   - a. being depressed after the death of a loved one
   - b. crying on an important anniversary 3 years after the death occurred
   - c. being "over it" and then slipping back
   - *d. an obsession with the deceased 2 years after the death

6. The grieving process usually takes longer if it involves the death of

   - a. a father
   - *b. a child
   - c. a mother
   - d. all take about the same time

7. According to Kubler-Ross the grieving family goes through:

   *a. the same stages of expressing grief as the dying patient
   b. the same stages except that there is no denial
   c. the same stages except that there is no anger
   d. none of the same stages

8. Grief work is best accomplished after a period of shock which lasts about:

   *a. 4 weeks
   b. 2 months
   c. 1 year
   d. immediately after the death occurs

9. When a loved one dies by suicide the family after displays feelings of:

   a. relief
   b. blaming each other
   *c. guilt
   d. none of the above

10. The period of mourning often lasts:

   a. a very short time
   *b. under 1 year
   c. over 2 years
   d. the rest of the survivor's life

Helping the Dying and Their Families

1. You tell a patient that he is seriously ill knowing that he has a terminal illness. He does not appear to want to talk about it. The best way to handle this situation would be:

   a. to repeat that he is seriously ill often
   b. to tell him that he is considered to terminally ill
   *c. to tell him that you are available any time should he want to talk about it
   d. tell him to cheer up

2. A patient expressing doubts about undergoing important surgery where there is a 50/50 chance of death, but if successful would prolong and increase his quality of life, can be helped by:

   a. getting the family to "push" him to decide to have it
   b. discussing fully the ambivalence about the surgery
   c. the pros and cons of the surgery should be fully discussed
   d. a and b
   *e. b and c

3. The "best" reaction on the part of a relative, when a patient has just died, in his/her/their presence, is to be

   a. stoic
   b. calm
   *c. crying
   d. detached

4. Relatives who talk to a patient who has recently died:

   a. display a morbid and dangerous attitude
   b. should be told it is futile
   c. are showing signs of a mental breakdown
   *d. are working to accept the grief in the future

5. Parents who have a child who died through so-called crib death can be helped by:

   a. reassurance that they are not guilty
   b. telling them to contact the National Death Foundation
   c. telling them such a death occurs at times
   *d. a and b
   e. all of the above

6. A dying patient who becomes angry with you when you are trying to help him should be told:

   a. It must be difficult to face what you are trying to face.
   *b. Life sometimes appears very unfair.
   c. I had nothing to do with it, let's talk about something else.
   d. Getting angry only makes matter worse.

7. If a dying patient in a Hospice tells you he is afraid there will be pain at the moment of death tell him:

   a. that most people are free of pain at the moment of death
   b. that pain is to be expected but that it will be brief
   *c. that there might be some pain but that everything will be done to keep him as comfortable as possible
   d. that no one can answer that question

8. In dealing with the dying and their families it is not harmful:

   *a. to admit your own concerns
   b. to appear flawless
   c. to claim to have resolved all conflicts about death
   d. all the above

9. Working with dying persons can eventually cause one:

   a. to increase his/her fear of death
   *b. to come to terms with one's anxieties about death
   c. to become stoic
   d. none of the above

10. If you are helping a teenage dying patient whose parents and physician forbid you to tell him/her of his/her condition, you should:

   a. respect that wish and evade the subject
   b. tell him/her anyway
   c. try to get the parents and physician to change by logic
   *d. encourage the youth to ask the physician directly

SAMPLE WORKSHOP SCHEDULE

9:00 - 9:15 A.M.	Introduction (guidelines)
9:00 - 10:15	Dealing with our own reaction to death
10:15 - 10:30	Break
10:30 - 11:00	Death in a cultural context
11:00 - 12:00 noon	The dying process
12:00 - 1:00 P.M.	Lunch
1:00 - 2:00	Grief and mourning
2:00 - 3:00	Helping the family cope with a dying relative; grief and bereavement
3:00 - 3:30	Group discussion and final questions
3:30 - 3:45	Summation
3:45 - 4:00	Evaluation

QUESTIONNAIRE A

1. Name something you lost that was precious to you (i.e., lost other than through death).

2. How did you react? (Include feelings in your answer.)

3. Whom did you tell about this loss?

4. How did the person(s) you told react?

5. As well as you can remember, how did you feel about this reaction?

6. How did you get over the loss?

7. What are your feelings right now?

QUESTIONNAIRE B

1. What is your earliest death-related memory? This is what happened:

2. I was about _____ years old at the time.

3. As best as I can remember the experience at the time was _____

4. When I think about the experience now, I feel _____

5. I think about the experience:

   _____ often _____ at times _____ seldom _____ not clear at all

6. The memory of this event is:

   _____ very clear _____ somewhat clear _____ not clear at all

7. Have you talked about this event with anyone?

   _____ often _____ seldom _____ never

8. What do you still need to do about this event, if anything, to come to terms with it?

9. What would you say to the person who died if you could?

10. What has helped you the most to accept this event?

QUESTIONNAIRE C

1. Write your own obituary.

____

____

____

____

2. What do you think would change in your life if you were diagnosed as having a terminal illness? Explain fully.

____

____

____

3. Have you made plans for your final days and after death occurs? If yes, what are they?

____

____

____

4. Have you made out a will? Why or why not?

____

____

____

5. What would you like to accomplish before your death?

____

____

____

6. What does death mean to you?

____

____

____

7. Do you discuss death openly with loved ones? Why or why not?

8. Do you think there are people you would like to make peace with or express positive thought to, prior to your death? Who are they and what would you say?

9. What type of funeral arrangements do you desire? Why?

10. Have you discussed these plans with anyone? Why or why not?

11. How have your views of death changed over time?

12. What question about death would you most like answered?

QUESTIONNAIRE C

1. If I could choose, I would want to die in the following manner:

2. The one question I would most like answered about death is:

3. If I had a terminal illness I would/would not like to be told. Explain.

4. The things I am afraid about death are:

5. Is suicide ever justifiable? Explain fully when or why not?

6. Euthanasia is sometimes the best alternative. Do you agree? Explain fully when or why not.

7. I hope to live till I am _____ years old.

QUESTIONNAIRE D

1. The way I see death is that it is:

diminished life ____
life as usual ____
perpetual development ____
waiting ____
other ____

cycle and recycle ____
the ending of the biological process ____
no state at all ____
explain ____________________

____

____

2. The way I think about death is that it is like:

sleep ____
altered states of consciousness ____
unresponsiveness ____

social death ____
phenomenological death ____
other ____ explain: ____

____

____

3. Which of the following statements about death comes closest to what you believe? Explain.

At the time of death we all become equal, both the great and small.

____

____

At the time of death our life is validated.

____

____

At the time of death we are all united into one.

____

____

At the time of death we all become separate.

____

____

Death is humanity's ultimate problem.

Death is life's ultimate solution.

Other

APPENDIX E

TYPES	CAUSES	STAGE
Killing	crime war suicide	infant
Disaster	natural man-made	child
Accident	unavoidable carelessness induced (alcohol, etc.)	youth
Disease	preventable terminal	young adult
Natural	explained unexplained (e.g., crib death)	middle age elderly

APPENDIX F

1. Even when death is inevitable, no one is willing to die. Unless he/she is suicidal or psychotic, no one really wants to die.

2. Reconciliation with the necessity of death is impossible. Preparation for death is also impossible, and no one can therefore help anyone to accept death.

3. Fear of death and dying is the most natural and fundamental fear. The closer one comes to death, the more intense this fear becomes.

4. Talking about death with a terminal patient will take away hope, and even may hasten his/her demise. This rule is particularly true for patients in whom recovery is still possible.

5. We must say as little as possible about death to dying patients. If questioned directly, a physician should turn queries aside, and use any means to deny, dissimulate, rationalize and avoid open confrontation.

6. Dying people do not really want to know about their prognosis. Otherwise they would ask about it. Unwelcome disclosure may involve the risk of suicide, psychosis, severe regression, and profound depression.

7. It is advisable that the physician, in consultation with the family, make decisions pertaining to treatment and giving information. When improvement or recovery is impossible, the patient should be left alone, except when his/her pain must be relieved. In this way, he/she will gradually withdraw from the world and die in peace, without disturbance or anguish.

8. Intensive scientific training, clinical experience, and knowledge of pathology automatically enable a physician to deal wisely with all phases of patient care, including the emotional and psychological dimensions of death.

9. When the family does not want a patient to be told about his/her diagnosis and outlook for recovery, the physician should abide by that decision. The doctor's principle concern, after it has been established that recovery is not possible, is to relieve pain and prolong survival. Psychological problems can be effectively managed with simple reassurance, adequate sedation, and, when death is imminent, referral to the clergy.

10. Dying patients are doomed. It is therefore reckless to inflict unnecessary suffering. Nothing anyone can do or say will make a substantial difference. After the patient dies, the family is no longer the responsibility of the hospital or the physician.

from Psychological Care of the Dying Patient, by Charles A. Garfield.

APPENDIX G

Ego coping mechanisms

Level I Primitive

delusion
perceptual
hallucination
depersonalization
reality distorting-denial

Levell II Immature

projection
denial through fantasy
hypochondriasis
passive-aggressive
acting-out behavior

Level III Neurotic

intellectualization
displacement
reaction formation
emotional dissociation

Level IV Mature

altruism
humor
anticipatory thought
sublimation
suppression

APPENDIX H

Fantasy Experience

We are now going to have a fantasy experience with death. Close your eyes and get comfortable. Relax. Take a moment to calm your mind. (pause)

Now see yourself walking into your doctor's office. See the furniture, the receptionist, and the other people in the waiting room. Feel the texture of the chair as you sit on it. Smell the smells of the office. (pause)

Now your name is being called. You get up and follow the nurse into the examining room. You wait for your doctor to arrive after the nurse leaves. Visualize the room where you wait all alone. Your doctor comes in. See him or her. He begins to talk about a recent test he made on you. You begin to feel uncomfortable. You want to hear but you don't. Then your doctor says, "Your test was not good. You are very seriously ill. We can never rule out hope but it is very, very serious." Get in touch with what your body is doing. Be aware of what you are thinking and feeling. Keep your eyes closed and stay with your reaction. What do you want to do next? (pause)

Time has passed and you are getting over the initial shock. Your condition has worsened. You are now nearing death. See yourself. Watch and listen for a moment. What do you wish you had done? What do you feel about yourself? See your family around you. What are they doing? What are you doing? (pause)

You are dying now. Your eyes go dark. Picture yourself at this moment. What do you experience? Flow with this moment. (pause) You are dead. What do you experience now? (pause)

You are dead and your obituary appears in the paper. What does it say? Just as important what does it not say? (pause)

Alright, we will end this fantasy now. You are not really dead, of course, and you will gradually re-enter full awareness of this room. When you are ready, open your eyes. (pause)

APPENDIX I

It is important to consider the patient's wishes about where he/she wants to die. Open lines of communication should be maintained, if at all possible, with the doctor, the family and the patient. Often, when no hope remains, a patient can be happier and the family more at ease if the patient dies in his own home. To accomplish this each will need adequate preparation and support from a hospice or home care program. When the step to remain at home and die has been agreed upon and taken by the patient and the family, the family needs to prepare the following in advance:

1. Write out the names, addresses and phone numbers of people who should be notified of the death: the doctor, close family members, the funeral director, the lawyer, and the insurance agent.

2. The attending doctor should be asked to visit the home soon after the patient's death to sign the official forms. This will relieve the family from dealing with the coroner's office unnecessarily.

3. Make it clear that the deceased should not be taken to the hospital.

4. The family should not call the fire department, the paramedics or the police in an attempt to "do something" at the time of death.

5. The matter of a funeral director should be discussed when appropriate as he/she will have to be informed when the death occurs.

Adapted from The Journal of Nursing, February, 1981. "Helping the Patient Who Wants to Die at Home," by Noreen McNairn, R.N., Ph.N., B.S.N., p. 66.

GRIEF SKETCH 1

Widow: You are a widow age 75 whose husband died six months ago. You are ill and in a nursing home. You feel sad and lost without your husband. Your children are living on the Coast, and you feel all alone. You have a very strong desire to give up and die so you can join your husband. You see nothing left for you to live for. You just keep telling the staff taking care of you, "Leave me alone and let me die."

Social Worker: In a nursing home you are assigned to take care of a 75-year-old widow who lost her husband six months ago. Your task is to help her with her grief, to get over the loss, and to get back to living again.

adapted from: Worden, J. William, Grief Counseling and Grief Therapy

HOW TO HANDLE THE FIVE STAGES OF DYING

Patient Behavior	Stage	Family Response
In effect the patient says, "It cannot be true." Patients often search frantically for a favorable diagnosis.	DENIAL	Understanding why the patient is grasping at straws. Patience and a willingness to talk are important.
The patient says, "Yes, but why me?" Deep anger follows and the patient may bitterly envy those who are well and complain incessantly about almost everything.	ANGER	Consider the patient is angry over the coming loss of everything: family, friends, home, work, play. Treat the patient with understanding and respect, not by returning anger.
The patient says, "Maybe I can bargain with God and get a time extension." Promises of good behavior are made in return for time and some freedom from physical pain.	BARGAINING	If the patient's bargaining is revealed, it should be listened to, not brushed off. This stage passes in a short time.
The patient grieves, and mourns approaching death.	DEPRESSION	Attempts to cheer up or reassure the patient mean very little. The patient needs to express sorrow fully and without hindrance.
The patient is neither angry nor depressed, only quiet, expectant.	ACCEPTANCE	News of the outside world means little, and few visitors are required. However, these few visitors are important. There will be little talk, and it is time merely for the presence of the family.

Based on the five stages of death outlined in On Death and Dying by Elizabeth Kubler-Ross.

MANAGING BEHAVIORAL PROBLEMS OF OLDER ADULTS

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The University of Chicago

Submitted to Gerontology Program, Elgin Community College, March 1983

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[1] The assistance of Elsie M. Pinkston, Ph.D. and the staff of the Elderly Support Project at the School of Social Service Administration of The University of Chicago is gratefully acknowledged.

TOPIC: Managing Behavioral Problems of Older Adults

SYNOPSIS:

This workshop provides the paraprofessional working with older clients with a methodology to understand, assess, and intervene with problem behaviors. The workshop delineates applicable behavior modification principles with special emphasis on improving positive behaviors as an alternative to current problems.

RATIONALE:

Specific behavior problems of older adults are often listed as justifications for limited activities, decreases in family contacts, criteria for service eligibility (either inclusionary or exclusionary), or a rationale for relocation or placement. The ability to accept, manage, and improve upon behavioral excesses or deficits is a critical element for planning for impaired older people. The decision to live alone or with desired family members is often dependent upon behavioral performance. Such behaviors as incontinence, excessive complaining, excess irrational conversation, demanding behavior, or frequent forgetfulness can make caring for a person or living with a person unpleasant if not impossible. More positive behaviors such as improved communication, engagement in activities, increasing self care and household tasks are extremely valuable.

Practioners working with the elderly deal with problem behaviors directly and provide information to older people and their families as to suggested changes vis-a-vis behavior problems to improve quality of life for all. Practioners can assist clients in understand the frequency and severity of problem behaviors, in monitoring changes in behaviors, and in changing their activities and responses to effect long-term positive changes. Behavior management methods may help the older client remain in their desired living situation in pleasant cooperative relationships to their caregivers. Workers employed in a variety of settings may make use of this approach, including long-term care facilities, adult day programs, senior centers, family counseling programs, hospitals, home health, mental health, and older adult housing programs.

RESOURCES

Hussian, Richard A. Geriatric Psychology: a Behavioral Perspective. New York: Van Nostrand Reinhold Company, 1981.

This book includes a good overview of psychological considerations and research for the population, delineates behavioral theory and techniques and presents a number of illustrations of making applications to human service clients, focusing both on client characteristics and differential settings.

Keller, James F., and Hughston, George A. Counseling the Elderly: A Systems Approach.

This book also includes an overview of gerontological theory and population characteristics. Although the major perspective delineated is a "social systems" approach this is often very compatible with a more behavioral approach and focuses on specific behavior problems in a number of settings. Particularly useful to participants will be the seventeen practice intervention situations on specific problems that range from chronic complaining, inter-familial problems, and non-compliance to medical and activity regimens.

Pinkston, Elsie M., Levitt, John L., Green, G. R., Linsk, N. L., and Rzepnicki, T. Effective Social Work Practice: Advanced Techniques for Behavioral Intervention with Individuals, Families and Institutional Staff. San Francisco, Jossey-Bass, 1982.

This book clearly outlines both the behavioral principles which underly this workshop and the intervention model which is outlined. The book includes an emphasis on how to select and train behavior change agents and includes material on the internal agency dynamics which limit or foster effective behavior change programs. Specific practice illustrations applicable to problem behaviors in the elderly include home based behavioral intervention, social group work and behavior problems and a program to reinstate self feeding problems in older persons in a long-term care setting.

Weiner, Marcella B., Brok, Albert J., and Snadowski, Alvin M. Working with the Aged: Practical Approaches in the Institution and in the Community Englewood Cliffs, New Jersey: Prentice Hall, Inc., 1978.

A basic book, well suited to the needs of beginning paraprofessional or professionals working with a variety of older persons in various settings. The book is especially useful in its straightforward presentation of a number of therapeutic modalities (i.e. reality orientation, remotivation, rehabilitation). Although not directly related to most of the workshop content this book provdes preliminary and additional information.

Zarit, Steven H. Aging and Mental Disorders: Psychological Approaches to Assessment and Treatment. New York: Free Press, 1980

A comprehensive clinical handbook for the elderly with a focus on cognitive/behavioral elements. This book covers a number of major issues and topics: community care, group and family approaches, treatment of brain disorders, issues of sexuality.

MODULE TITLE: MANAGING BEHAVIOR PROBLEMS OF OLDER ADULTS

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
A. Behaviors and the older adult	1. Discuss the applicability of behavior modification procedures for older persons; specify at least three kinds of problems, situations or characteristics of older persons that are appropriate for behavior management techniques. 2. Be able to explain the difference between a discrete behavioral problem and a cognitive or emotional disturbance (that it is visible to an outsider; involves doing something; usually involves feelings as well.) 3. Describe the three ways people generally respond to behaviors of others; attend, ignore, or reprimand.	a. Use of discussion questions (see sample schedule). b. Use of blackboard or overhead to note important points. c. Elicit examples of each idea from participants or supplement from own experience. d. Use of small groups for the discussion if size and availability of leaders warrant. e. Use of a simple illustrative exercises; role play a simple typical interaction between a staff person or caretaker and older client to use as a reference regarding what was positive v.s. negative; what was an actual behavior v.s. a feeling expression, etc.

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MODULE TITLE: MANAGING BEHAVIOR PROBLEMS OF OLDER ADULTS

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
	4. Illustrate how most common problem behaviors can be reconceptualized into deficits in positive behaviors.	
B. The behavioral paradigm	1. Explain how and why behavior is effected by what preceeds and follows it. 2. Explain definitions of the following three components of any behaviors: antecedents, behaviors, and consequences. 3. Give examples from everyday life of older people of how problem behaviors are strengthened by environmental consequences and how more positive alternatives can be developed and sustained through changing cues and consequences.	a. Use of simple poster or drawing showing the three components (See Figure 1). b. A short lecture delineating the basic behavioral and learning theories underlying reinforcement and stimulus control. c. Practicing anecdotal recording on some example situations. (See Figure 2).

MODULE TITLE: MANAGING BEHAVIOR PROBLEMS OF OLDER ADULTS

TOPICS	**STUDENT COMPETENCIES: At the end of the module, students should be able to--**	**SUGGESTED PRESENTATION METHODS**
C. Assessing Behaviors	1. Conduct a short interview with clients or significant others who have direct knowledge of client to determine reported behavioral strengths, problems, and frequencies. 2. Perform simple structured and unstructured behavioral observations. 3. Teach simple recording methods to others in the environment (client or staff or family.	a. Review interview guide (See Figure 3). b. Develop a recording method as a group for 3 sample situations (See Figure 4). c. Use a role play to have one participant teach another to record the behavior of a third.
D. Improving Behaviors	1. Understand & suggest appropriate situations to apply 3 major behavioral procedures: cueing, changing consequences (reinforcer changes), and punishment. 2. Discuss the use of assessment and	a. Lecture/discussion reviewing possible interventions (see sample schedule). b. A group fill-in-the-blank discussion of when to use what procedure (See Figure 5). c. Development of an intervention plan for

MODULE TITLE: MANAGING BEHAVIOR PROBLEMS OF OLDER ADULTS

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
	frequency data to make intervention decisions. 3. Explain the use of three delivery systems--contracting, tokens and reinforcing the behavior manager.	one or two sample cases (or case examples elicted from the group.
E. Evaluating the results	1. Use behavior records to determine changes in behavior patterns. 2. Use client and staff reports to add to or interpret those changes.	a. Review of 2 sample graphs of behavior changes. b. Brief discussion of how we know behavior has changed and does it really make any difference. c. Discuss the need for maintenance procedures.

FIGURE 1

ANTECEDENTS

- Instructions
- Reminders
- Criticism (when it leads to something else)
- Time recorders (clocks, calendars, appointment books)
- Schedules
- Notes
- Warnings

BEHAVIORS

- Positive/Negative
- Excess/Deficit

CONSEQUENCES

- Reinforcers
    - Concrete
    - Social
    - Positive/Negative
- Punishers

SUMMARY:

An antecedent lets you know when a reinforcer will follow a behavior.

Reinforcers are anything that follows a behavior that tends to increase its future occurrence. They are usually pleasant events or things.

Punishers follow a behavior and tend to decrease its future occurrence. They are often followed by side effects.

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Figure 2

Anecdotal Record Worksheet

ANTECEDENT	BEHAVIOR	CONSEQUENCE

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Figure 3

Interview Guide to Assess Problem Behavior

1. What are your general concerns right now?

2. What is going well in the situation you are concerned about right now concerning ________________________(the older person)?

   A. How does _____ contribute to the family/program?
   B. What things can _____ do for him or herself? What strengths are present?
   C. What things should not change?
   D. Are there some additional areas that should change besides the behaviors you have described?

3. I am now going to ask some questions to help us both understand better what we should work toward.

   A. If we were totally successful what would be the result for your program/family/etc.?
   B. Exactly what would change and how would things be different?
   C. How is this different from what is happening now?

4. Can you describe the problem behavior(s) in more detail?

   A. When do they occur? (times)
   B. How often do they occur?
   C. What things occur prior to the behavior? (antecedents)
   D. How long has this been happening?
   E. Are there situations or conditions when the present problem occurs but aren't a problem?
   F. How have you dealt with the problem in the past? Is this successful?
   G. Who helps with the problem? Is there anyone who deals with it more successfully than others?
   H. Why is this a problem that needs to be solved right now?

5. What are the consequences of the behavior?

   A. Has the older person been excused from things that might not otherwise occur?
   B. How do people respond when the behavior occurs? Is the person given or denied special attention because of the behavior?

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Figure 5

INTERVENTION SELECTION WORKSHEET

If assessment reveals:	Then intervention includes:
Behavior does not occur at all	Modeling, cueing, instructions
Behaviors occur but are weak or infrequent	Shaping, increasing reinforcement
Excessive or undesirable behavior	Differential attention; ignoring, move to unreinforcing environment; reinforce incompatible behaviors
Dangerous behaviors	Remove person from reinforcing environment; prompt desirable behaviors
Alternative behaviors-limit positive behaviors (i.e., pacing, nervousness, crying, etc.)	Introduce incompatible activities, i.e., relaxation

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Figure 4

SAMPLE PROBLEMS AND CASE SITUATIONS

1. Mrs. Jones is a resident in a highrise for the elderly. The management and senior center staff are very concerned about her forgetfulness. She comes down for activities on the wrong day and time, often forgets or loses her keys, and occasionally gets lost on the street. She often forgets to pay her rent or occasionally insists on paying it when it is not due. She is well dressed, cares for herself well, enjoys social activities, and is well accepted by other tenants. She has a daughter who calls daily, is very concerned about her but visits only monthly.

2. Mr. Smith is a 70 year old gentleman who lives with his wife in their own home. His wife has called and asked about the local day center accepting him. She says that he is depressed since retiring and very unoccupied. He refuses to help around the house and complains frequently.

3. Miss Phillips is an 83 year old resident of a nursing home. She has been very involved in helping the receptionist, helping deliver mail, and greeting visitors and asking them to sign the registration book. Recently, however, she has begun to experience problems with urinary incontinence. The receptionist and some of the other residents have suggested she not be allowed to come to the lobby because of the odor and embarrassment.

4. Mr. Carlson is an 85 year old man with advanced organic brain syndrome. His wife is concerned that he is not eating well. She reports spoon feeding him at every meal. At holiday dinners, however, when other family members are around he eats independently. She also takes full responsibility for other personal tasks, dressing, bathing and toileting him. She reports that he is totally unable to respond to conversation most of the time.

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CONCLUDING INFORMATION AND EVALUATION

How useful were the workshops in regard to:

	Very Useful	Fairly Useful	Not Useful	N/A
1. Learning skills needed for current practice				
2. Learning skills needed for future practice plans				
3. Developing behaviorally based programs for older people				
4. Satisfying general interest				

5. Would you say your personal reaction to behavioral approaches with the elderly has become:

_____ More receptive _____ No change _____ More critical

Why?____

____

____

6. Are you interested in learning more about:

_____ Behavioral approaches to clinical practice

_____ Social work with older people

7. Additional comments or suggestions:

EVALUATION

BEHAVIOR PRINCIPLES KNOWLEDGE INVENTORY

DIRECTIONS: The following questions are designed to determine your ideas about human behavior, particularly as applied to older persons. Read each question and each of its four possible answers. Sometimes more than one could be correct under certain circumstances; however, you should select the best answer or the one that is most generally true. Completely circle the letter beside the best answer.

EXAMPLE: Probably the most important influence in a person's life is his

A. Hobbies
B. Work
C. Television
D. Friends and family

Please do not consult others while deciding how to answer the question. Be sure to circle only one letter for each question. Be sure to answer every question even if you must guess.

1. Problem behavior in older people is often

   A. Impossible to change due to deeper emotional problems.
   B. Not related to learning, as older persons are unable to learn.
   C. Learned responses based on the older person's abilities and the attention they do or do not receive.
   D. Due to the changes of old age.

2. Most behaviors can be classified as desirable or undesirable. Desirable and undesirable behaviors are most alike in that they are:

   A. The result of emotions and feelings.
   B. Habits and therefore difficult to change.
   C. Ways people express themselves.
   D. The result of learning.

3. If you were trying to encourage a very silent older person to talk more, you should first:

   A. Compliment the older person after each conversation.
   B. Compliment the older person for saying a sentence.
   C. Compliment the older person for saying a word or any vocalization.
   D. Criticize the older person for being so quiet.

4. An older person is having a difficulty with housekeeping. Family members have encouraged the person to clean by praising and complimenting the older person each time he or she does any housekeeping activity. The next step should probably be to

   A. Have a talk about how pleased you are and then not concentrate on complimenting the older person for housekeeping.
   B. Try to praise the person for cleaning about once a week.
   C. Praise and compliment the older person almost every time he or she cleans.
   D. Continue to praise the older person every time he or she cleans.

5. When giving a compliment about a behavior, it will often be better to include:

A. Physical contact such as hand holding or hugging.
B. Criticism for a behavior problem which occurred earlier.
C. Reminders of some other behavior which is not occurring.
D. Questions about what made the behavior occur.

6. Mrs. P. has noticed that since her mother began to have memory problems, she has been visiting her mother less frequently. This is probably because:

A. She believes the visits are harmful to her mother.
B. She has less time to visit her mother due to other family responsibilities.
C. Her visits are no longer as rewarding to her, so she has changed her visiting behavior.
D. She no longer loves her mother.

7. Family members may ask older relatives fewer questions because:

A. The relatives provide fewer or less satisfying answers.
B. Their relatives are no longer interested in responding to them.
C. They do not wish to confuse the older person.
D. They are no longer interested in what the older person has to say.

8. The following all may help increase conversation with an older person except:

A. Ask more questions.
B. Allow more time for the older person to respond.
C. Point out to the older person that their talking has gotten worse.
D. Bring pictures or interesting items to the older person to discuss together.

9. An older man is beginning to redress himself while recovering from a stroke. You notice he is having a difficult time and want to encourage him. When would it be most helpful for you to first encourage or praise him for his progress?

A. When he has completely finished dressing himself.
B. When he asks to be allowed to try to dress himself.
C. When he gets his underwear completely on.
D. When he makes the first step in putting on his underwear.

10. The first step in eliminating a problem behavior is to:

A. Carefully observe the behavior.
B. Compliment the person when he is not exhibiting the behavior.
C. Punish the person for misbehavior.
D. Seek help from someone who is more objective.

11. Which of the following is not an important step in a behavior change program?

A. Be sure the older person feels ashamed of his misbehavior.
B. Decide on a particular behavior that you wish to change.
C. Break the selected behavior down into smaller steps.
D. Select a proper time and place for measuring the behavior.

24. When people get older, they

    A. Are more sensitive to the taste of foods.
    B. Are less sensitive to the taste of foods.
    C. Complain more about food because they are unhappy.
    D. Have no change in sensitivity to taste.

25. One reason depression occurs in older persons is:

    A. Life becomes overwhelming.
    B. The older person no longer cares about living.
    C. Older persons generally become very angry.
    D. Enjoyed activities are lost or occur infrequently.

26. Once a new behavior is learned, to help continue the behavior it is important to:

    A. Avoid calling attention to the behavior as the person has successfully learned it.
    B. Scold the person if he or she seems to forget to engage in the behavior.
    C. Ignore the behavior as further attention to the behavior may embarrass the person.
    D. Reward or praise the person when he or she does engage in the behavior.

27. Because of arthritis, Mrs. B. has difficulty in continuing her favorite activity of hand sewing. Her family should:

    A. Take her sewing materials away as they will depress her.
    B. Ignore this problem entirely.
    C. Let her sew and correct it when she is asleep.
    D. Encourage other activities without emphasizing her sewing.

28. Mrs. M. often cries, usually over small things. Her relatives should:

    A. Find out the reasons for her crying.
    B. Compliment her and talk with her when she is not crying.
    C. Talk to her if she cries.
    D. Help her avoid things that upset her.

29. Compliments are most effective when:

    A. Used prior to the behavior occurring.
    B. They are not given in connection with a particular behavior.
    C. Given immediately after the behavior occurs.
    D. Given fifteen minutes after the behavior occurs.

30. Successful change depends most on:

    A. Changing the attitudes of the older person.
    B. Understanding the limitations of old age.
    C. Careful attention to the events that occur before and after a behavior.
    D. How long the prior behavior has persisted.

17. How often a behavior occurs is probably most related to:

A. The person's attitude about his or her behavior.
B. What happens to the person at the same time the behavior occurs.
C. What happens to the person just before the behavior occurs.
D. What happens to the person just after the behavior occurs.

18. Which of the following is true about criticizing a person for their behavior?

A. Criticism shows concern and respect for the person.
B. Criticism should be delayed until it can be carefully determined that it is really necessary.
C. Criticism can be used to teach new skills or behaviors.
D. A person who is criticized may then become upset or aggressive and may develop additional undesired behaviors.

19. The most likely reason older persons would show undesirable behavior in the presence of other family members is:

A. They are expressing anger.
B. They learned to behave this way and that it will receive attention.
C. The misbehavior is due to the changes of aging.
D. They have not been told that their behavior is undesirable.

20. If you want to make a behavior a long-lasting habit, you should:

A. Compliment or reward it each time it occurs.
B. First reward it every time and later reward it occasionally.
C. Promise some pleasant event or gift if it occurs.
D. Give several reasons why the behavior is important and remind the person of these reasons frequently.

21. To record, graph and note the direction of the change of a behavior is:

A. A minor, optional step in a behavior change program.
B. An important step in a behavior change program.
C. A procedure employed only by scientists for research reasons.
D. Time consuming and complicated and useful only in special cases.

22. The best explanation of why many older people have few activities to engage in is:

A. They are no longer interested in activities.
B. They are not rewarded for engaging in activities.
C. They have become grouchy and lost friends.
D. They believe they cannot do any of the expected activities.

23. As older people lost their abilities to see, move, hear, and taste,

A. They receive more attention and rewards.
B. They receive fewer rewards and attention.
C. They do not notice the change in abilities.
D. They note the change but are not interested or do not care.

12. The Brown family is very concerned about their father, whose behavior has changed since his 80th birthday. He often gets lost when outside the house, complains frequently, has become argumentative, no longer dresses properly, and is forgetful. The best approach to begin to help with these behavior problems is:

    A. Try to quickly eliminate all of these problems at once.
    B. Select a few problems to deal with first.
    C. Select the one behavior which is the biggest problem and concentrate on changing that first.
    D. Wait about a month before beginning to try to help with these problems to be sure they are stable and persistent.

13. Which would be the best example of a way to praise an older person who has demonstrated improvement in his walking?

    A. Good.
    B. I love you.
    C. You are doing much better. You should be walking by yourself within a month or so.
    D. I really like the way you are using your cane. You are holding it in the middle of the handle and placing it directly on the floor.

14. A major problem has been for Mrs. Smith to spend more time out of her bed. Her husband, Mr. Smith, wants to help her to change this and wants to measure the relevant behaviors. Which is the best way to do this?

    A. Each day record when she has spent time out of bed.
    B. Record her behavior all day long, to determine what occurs before, during and after the time she is in bed.
    C. Each week, make note of how easy or difficult it is for her to get out of bed.
    D. Require Mrs. Smith to keep her own record each week.

15. The Jones family is concerned about their grandmother's constant complaining. Which of the following methods would usually be the best technique to reduce the number of complaints?

    A. Explain to Grandmother why the behavior is undesirable as well as why they think she needs to complain so much.
    B. Watch for times when Grandmother is not complaining (talking about other things). When this occurs praise or compliment her and engage in discussion.
    C. Criticize Grandmother when she complains and remind her to stop complaining.
    D. Try to avoid talking to Grandmother altogether.

16. If an older person receives less and less attention or praise for a behavior, what is most likely to happen?

    A. He or she may behave that way less and less.
    B. He or she will be more likely to behave that way for a long time.
    C. He or she will learn to distrust those who have been giving less attention or praise.
    D. He or she may increase the behavior.

Code (Correct Answers):

1. C
2. D
3. C
4. C
5. A
6. C
7. A
8. C
9. D
10. A
11. A
12. C
13. D
14. B
15. B
16. A
17. D
18. D
19. B
20. B
21. B
22. B
23. B
24. B
25. D
26. D
27. D
28. B
29. C
30. C

Adapted from KEPAC. O'Dell *et al*, 1979.

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SAMPLE WORKSHOP SCHEDULE

9:00 - 9:10 A.M.	Overview of workshop
9:10 - 9:20	Introduction of participants
9:20 - 10:00	Discussion and definition of the following ideas: (possibly break into two small groups) 1. What do we mean by an older adult? 2. What is behavior? 3. What is the difference between problem behaviors and acceptable behaviors? 4. How do we know about behaviors? 5. How do we respond to our own behaviors? 6. How do we respond to the behaviors of others? 7. What are some common problem behaviors of older adults? 8. What are some common positive behaviors of older adults? 9. What are some common problem behaviors of those who care for older adults? Are there some counterparts we can describe as more positive behaviors?
10:00 - 10:15	Completion of "Behavior Principles Knowledge Inventory"
10:15 - 10:35	Break
10:35 - 11:00	Mini-lecture: The Behavioral Paradigm
11:00 - 11:15	Questions and discussion
11:15 - 12:15 P.M.	Ways of assessing behavior 1. Self reports 2. Interviewing methods (of clients and staff, others) 3. Observation of behaviors a. Anecdotal b. Recording frequency of behaviors c. Asking the client or others to record frequencies (when you are not there)
12:15 - 12:30	Simulation assessment on one sample case
12:30 - 1:30	Lunch
1:30 - 1:45	Reconvene. Summary and questions about morning session.
1:45 - 2:10	Graphing of behavior patterns
2:10 - 3:00	Discussion of major treatments for behavioral problems 1. Setting the signals - cueing and scheduling

Workshop Schedule (cont.')

	2. Adjusting the consequences Stopping rewarding inappropriate behaviors Increasing rewards of positive behaviors
	3. Dealing with severe behaviors Punishment and limit setting - effects and side effects Time out Ignoring
	4. Delivery systems - contracts, tokens, reinforcing the behavior manager
3:00 - 3:45	Trying it out: developing a plan for one or two sample cases. Use of role play to try out procedures.
3:45 - 4:00	Evaluating results: use of continuing assessment data
4:00 - 4:15	Summary/Review/Additional questions
4:15 - 4:30	Distribution and completion of Behavior Principles Knowledge Inventory post-test and evaluation.

Workshop Curriculum

Prepared by Angela R. Falcone, B.S.N., M.P.H.
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Cornell Medical College, Department of Public Health

TOPIC:

Assessment of Older Clients

SYNOPSIS:

Assessment is the base from which older persons' service needs are determined, referral plans are made, care plans are developed and followed, and progress is evaluated. This workshop will help participants to assess people and use the assessment information for making service decisions.

RATIONALE:

All decisions are based on information. If the information is accurate and complete, the decisions that result are useful. The decisions made about whether a person has service needs and how to arrange for their management are critical if older persons are to receive services appropriately. Too often the elderly receive services that are not best suited to their needs, or receive no service at all because the decisions made about their service needs either are inaccurate or incomplete.

The use of a systematic information base, an assessment, by all workers in the long-term care system for making referral and care planning decisions should lead to the receipt of needed services in a timely fashion. The purpose of this workshop is to provide participants with assessment, referral, and care planning skills.

Paraprofessionals working in community programs frequently are called upon to be gatekeepers of long-term care services. They are expected to accomplish the most difficult and sensitive activity associated with service provision, that is, assessing people to discover their potential needs. Assessment and referral planning can be accomplished successfully by paraprofessionals if they are given the tools and skills necessary to do so. Workers can utilize these tools and skills in outreach, senior center, homemaker/home health aide, and information and referral programs.

RESOURCES:

1) Printed Materials

Brody, Elaine N., Long-Term Care of Older People, New York, 1977.

This well known book is listed as A Practical Guide. It addresses itself to the definition and history of long-term care, pinpoints population demographics, provides descriptions about assessment and decision-making for referral and other activities, and includes case material and various forms.

Densen, Paul M., Ellen W. Jones, "The Patient Classification for Long-Term Care Developed by Four Research Groups in the United States," Medical Care, Vol.14, No.5, Supplement, May 1976, pp.126-133.

Article demonstrating the bases used for developing and using a classification system . Criteria, rationale for item inclusion, and purpose of use are detailed.

Falcone, Angela R., "Resident and Patient Care and Services," Long-Term Care Administrator's Desk Manual, Dulcy B. Miller, Ed., Panel Publishers, Inc., 1982, pp.6011-6027.

Chapter in an anthology describing assessment, its attributes, how and when it is accomplished, and how it is used for determining service needs, making eligibility decisions, care planning, discharge planning, and quality assurance. Care management, which encompasses the above uses, is detailed. This is a most explicit source of how to accomplish assessment, referral, and care planning.

Goldberg, Leo, C. Benoit, The Problem/Need Oriented Approach to Planning and Evaluating Patient Care, Medallion Communications, 1978.

Identifying a person's problems or needs is the focal point for planning and, after service is delivered, for evaluating the efficacy of care. This publication addresses planning and evaluation from this point of view.

Kane, Rosalie A., Robert L. Kane, Assessing the Elderly - A Practical Guide to Measurement, The Rand Corp., Lexington Books, MA 1981.

This book presents the most extensive review of existing assessment, classification, and other measurement tools available. It describes the development, testing, and some uses of these tools.

Katz, Sidney, L. Halstead, M. Wierenga, "A Medical Perspective of Team Care," Long-Term Care: A Handbook for Researchers, Planners, and Providers, N.Y., 1975.

The importance of assessment information and its use is detailed. It stresses that narrowly focused or possibly conflicting treatment plans result when the assessment is profession or specific purpose oriented rather than client oriented. Validation of a person's problems or needs is most likely from a systematically derived assessment.

Mayers, Marlene Glover, A Systematic Approach to the Nursing Care Plan, Second Ed., N.Y., 1978.

A book describing the problem solving process for care planning and its component parts. It demonstrates clinical applications of nursing care plans in multiple health settings.

McCaslin, Rosemary, "Next Steps in Information and Referral for the Elderly," Gerontologist, Vol.21, No.2, April 1981, pp.184-193.

This article summarizes the information and referral functions that address direct services to clients and the resulting interventions with the service system. It recommends more research to validate existing theory and to explore new approaches upon which practice can be based.

Ryder, Claire F., William F. Elkin, Dana Doten, "Patient Assessment, An Essential Tool in Placement and Planning of Care," HSMHA Health Reports, Vol.86, No.10, pp.923-932.

Article describing the necessity of assessment, its components, and its value for making accurate decisions for the chronically ill in long-term care.

Williams, T. Franklin, "Assessment of the Geriatric Patient in Relation to Needs for Services and Facilities," Clinical Aspects of Aging, 1978.

Article describing the special characteristics of geriatric patients and the role assessment plays in obtaining appropriate treatment decisions.

2) Audio-visual materials

None recommended

3) Other materials

Assessment and Classification Tools

Index of ADL, Sidney Katz and C.A. Akpom, Medical Care, Vol.14, No.5, May 1976, pp.116-118.

Long-Term Health Care Minimum Data Set, National Committee on Vital and Health Statistics, DHEW, July 1979.

Long-Term Care Information System Assessment Process, Angela R. Falcone, Michigan Office of Services to the Aging, Cornell Medical College, Department of Public Health, 1978.

Multidimensional Functional Assessment: The OARS Methodology, Eric Pfeiffer, Duke University Center for the Study of Aging and Human Development, Durham, NC, 1975.

Patient Assessment Computerized, Carl Adams and Judy Williams, National Health Corporation, Murfeesboro, TN, 1980.

Patient Classification for Long-Term Care Users Manual, Ellen W. Jones, Harvard Center for Community Health and Medical Care, U.S. Government Printing Office, 1974.

MODULE TITLE:

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
A. Care Management	1.a. Understand that care management is comprised of the four ordered elements of assessment, service need identification, planning, and service delivery. b. Be aware that the next step restarts care management with a reassessment used for evaluating the client's progress and effectiveness of the plan. 2. List the elements in order and define them.	a. Teach the care management concept while drawing a cycle on the chalkboard starting with assessment. (Attachment A) b. Ask the participants as a group to give definition for each of the care elements writing their terms on the chalkboard. Assessment: A description of what is, as it exists. It does not have decision-making properties nor is it subjective or interpretive. To be most useful for paraprofessionals it must be comprehensive, objective, and in a language understood in common by all caregivers. Need Identification: The problems or needs a person exhibits. This is determined from assessment information. Planning: Decision-making about the problems/needs to address, goal setting, service approaches. Directions to follow for providing service. Service Delivery: Following the planning directions.
B. Assessment	1. Assess a client. 2. Determine the client's service needs.	a. Teach the group how to assess a client by giving each participant a copy of a comprehensive assessment form and explaining the meaning of each of its items of information. Describe why each item is important and what possible needs a person would have if the assessment of the item was not within normal ranges. Point out combinations of assessment items that may indicate a service need. (Attachment B)

MODULE TITLE:

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
		b. Have each participant fill out an assessment on a person known to the participant as the meaning of each item is taught.
		c. Have each participant identify his/her person's service needs.
		d. Lecture on methods for gathering assessment information: interview, observation and from existing documents.
		e. Form small groups of 4 to 6. Have each participant complete an assessment by interviewing and observing another participant who is playing a role. The other group members look on.
C. Referral Planning	1. Develop a referral plan	a. Demonstrate how referral decisions are made by making up a referral plan for one of the assessments completed. Include services needed, potential frequency of need, whether the person's social support will provide any of the needed services, the names of the available service providers, and the available methods of payment. Match the services needed with the available providers to lay out possible referral options for client choice. (Attachment C)
	2. Implement a referral plan	b. Have the group select one of the options as if they were the client. Ask them to enumerate the next steps of notifying the service provider(s) from whom the client is to receive services, send the assessment information to the provider(s) as the referral plan, and make follow-up plans.
		c. Have each participant develop a referral plan for one of the people they have assessed in the workshop.

MODULE TITLE:

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
D. Care Planning	1. Identify that problems and care decisions are to be addressed by a care plan. 2. Understand why goals are set. 3. Be prepared to make suggestions about the kind of care to deliver. 4. Understand that reassessment is necessary for evaluating goal achievement and for future decision-making.	a. Demonstrate how to develop a care plan using one of the completed assessments as an example. Include problem identification, goal setting within specified time frames, specific care approaches including frequency of performance, supplies and equipment to be used, and the identity of the caregivers (Attachment D). b. Demonstrate evaluation by using a reassessment and match it with the set goals to determine goal achievement.

MODULE TITLE: Assessment of Older Clients

SAMPLE WORKSHOP SCHEDULE

9:00 to 9:15	Introduction of instructor and participants with each stating his/her affiliation and interest in the workshop
9:15 to 9:30	Overview of day's agenda and workshop's objectives
9:30 to 10:15	Care management and definition of its elements
10:15 to 10:30	Break
10:30 to 12:00	Learning how to assess with participants completing an assessment as information is presented
12:00 to 1:00	Lunch
1:00 to 1:15	Participants identify service needs
1:15 to 1:30	Lecture on gathering assessment information by interview, observation, from documents
1:30 to 2:15	Role play in small groups - participants assess each other
2:15 to 2:30	Demonstrate how to develop a referral plan
2:30 to 3:00	Participants develop a referral plan
3:00 to 3:15	Break
3:15 to 3:40	Demonstrate care planning and evaluation
3:40 to 4:00	Discussion, summary, and workshop evaluation

MODULE TITLE: Assessment of Older Clients

ASSESSMENT-PARTICIPANT EVALUATION

1. True *False The product of an assessment is a decision.

2. True *False Care management is a separate activity from assessment.

3. *True False Service needs are determined by using the assessment.

4. *True False Continuous care management occurs when clients are reassessed.

5. The ordered care management elements are

a. assessment, evaluation, planning, service provision
b. evaluation, need identification, assessment, planning
c. problem identification, assessment, planning, service provision
*d. assessment, need identification, planning, service provision
e. none of the above

6. Gathering assessment information is accomplished by

a. interview
b. observation
c. from documents
*d. all of the above
e. none of the above

7. The best way to find out what a person needs is to

a. ask the person what (s)he wants
b. listen to what the family says
*c. do an assessment
d. observe him/her at home
e. none of the above

8. The best referrals are the ones in which

*a. needs match services available
b. the client receives what he wants
c. services are adjusted to the client
d. the services are free
e. the person is assessed by people with different health and social viewpoints

MODULE TITLE: Assessment of Older Clients

9. Care plans are developed

   a. only by some agencies
   *b. to provide care directions
   c. to keep track of the services provided
   d. to evaluate problems
   e. to be an assignment sheet

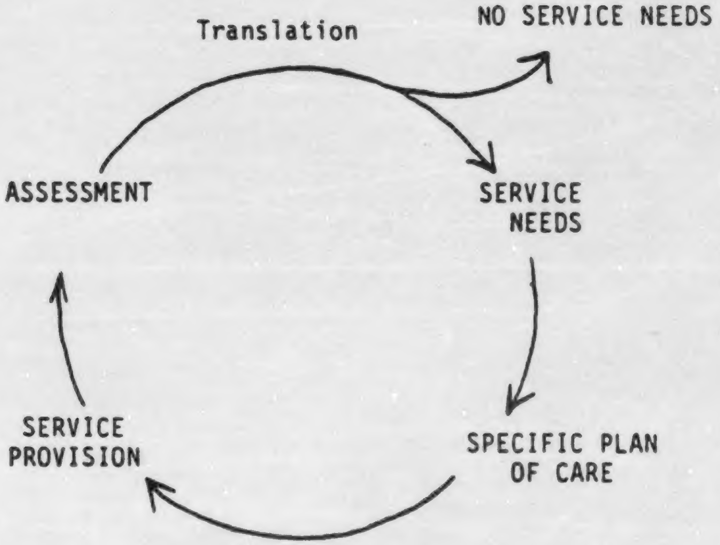
10. Goals are set

   a. for a client depending on his/her needs
   b. to show that with a service people improve
   *c. as a benchmark to judge progress in an evaluation
   d. only as something to work toward
   e. none of the above

Attachment A

LONG-TERM CARE INFORMATION SYSTEM

CARE MANAGEMENT CYCLE


Translation
NO SERVICE NEEDS
ASSESSMENT
SERVICE NEEDS
SPECIFIC PLAN OF CARE
SERVICE PROVISION

1979 ©Long-Term Care Information System

Attachment B

ASSESSMENT PROCESS

NAME	HOME ADDRESS	TELEPHONE NUMBER

SUMMARY OF PROVIDERS

RECORD NUMBER	PROVIDER NAME	PROVIDER ADDRESS	TELEPHONE NUMBER	PROVIDER NUMBER	PROVIDER SOURCE	DATES OF ADMISSION	DATES OF DISCHARGE

BIRTHDATE MONTH | DAY | YEAR

BIRTHPLACE SPECIFY STATE OR COUNTRY
☐ USA ☐ OTHER ____________

SEX ☐ MALE ☐ FEMALE

MARITAL STATUS ☐ MARRIED ☐ SEPARATED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN

RELIGIOUS PREFERENCE
☐ CATHOLIC ☐ OTHER ____________
☐ JEWISH-SECT ____________
☐ PROTESTANT-SECT ____________

RACIAL/ETHNIC BACKGROUND
☐ AMERICAN INDIAN OR ALASKAN NATIVE
☐ ASIAN OR PACIFIC ISLANDER
☐ BLACK (NOT HISPANIC)
☐ HISPANIC
☐ WHITE (NOT HISPANIC)
☐ OTHER ____________

EDUCATION
☐ GRADUATE COLLEGE
☐ ELEM./HIGH SCHOOL GRADES COMPLETED ______
☐ UNDERGRADUATE COLLEGE Degree or yrs. ________
☐ SPECIAL EDUCATION
☐ TRADE, TECHNICAL VOCATIONAL
☐ NO SCHOOLING
☐ HIGH SCHOOL DIPLOMA
☐ UNKNOWN

FAMILY INCOME
☐ $20,000 OR MORE
☐ $15,000 - $19,999
☐ $10,000 - $14,999
☐ $5,000 - $9,999
☐ $3,600 - $4,999
☐ $2,600 - $3,599
☐ $2,599 OR LESS
☐ UNKNOWN

USUAL LIVING ARRANGEMENTS

	ALONE	SPOUSE	OTHER
☐ HOME/APARTMENT			
☐ RENTED ROOM(S)			

☐ DOMICILIARY/PERSONAL CARE FACILITY
☐ HEALTH CARE FACILITY-TYPE ____________
☐ OTHER ____________

HEALTH CARE COVERAGE
☐ MEDICARE # ____________
☐ MEDICAID # ____________
☐ OTHER TYPE ____________
____
SOCIAL SECURITY # ____________

NUMBER OF LIVING CHILDREN ______
SON(S) ______ DAUGHTER(S) ______

EMPLOYMENT STATUS
☐ EMPLOYED ☐ RETIRED
☐ PRE-RETIREMENT ☐ PENSION
☐ POST-RETIREMENT ☐ NO PENSION
☐ UNEMPLOYED ☐ NEVER EMPLOYED
☐ UNKNOWN

USUAL OCCUPATION
☐ HOMEMAKER ☐ NONE
☐ OCCUPATION OUTSIDE THE HOME SPECIFY ____________

NONINSTITUTIONAL LIVING SPACE
☐ AVAILABLE ☐ NOT AVAILABLE D

YES	NO	
		ENTRY STAIRS
		ELEVATOR OR OTHER CONVEYANCE AVAILABLE
		TOILET ROOM SAME FLOOR LEVEL AS BEDROOM
		KITCHEN SAME FLOOR LEVEL AS BEDROOM

SOCIAL SUPPORT WILLING AND ABLE TO PROVIDE

YES	NO	
		ACTIVITIES OF DAILY LIVING SUPERVISION
		HOUSEKEEPING
		LIVING SPACE
		MEAL PREPARATION
		SHOPPING
		TRANSPORTATION
		OTHER

DIRECTORY OF HEALTH CARE PROFESSIONALS & OTHERS

	NAME	ADDRESS	TELEPHONE NUMBER	DATES OF ASSESSMENT	TYPE OF SERVICE OR LEVEL OF CARE: CURRENT	TYPE OF SERVICE OR LEVEL OF CARE: RECOMMENDED	METHOD OF PAYMENT: CURRENT	METHOD OF PAYMENT: EXPECTED
REFERRING PHYSICIAN								
ATTENDING PHYSICIAN								
ALTERNATE PHYSICIAN								
DENTIST								
PODIATRIST								
PHARMACY								
FUNERAL HOME								
PERSON(S) TO BE NOTIFIED								
OTHER								

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Long Term Care Assessment Training Center 421 E. 70th Street New York, NY 10021

MEDICAL STATUS

CHECK BOXES WHICH APPLY.
FILL IN SPACES AS INDICATED

	NO IMPAIR-MENT	IMPAIRMENT (ATTEMPTED) COMPENSATION SPECIFY	IMPAIRMENT NO COMPEN-SATION	COMPLETE LOSS	DATE OF CHANGE (IF ANY)
SIGHT			D		
HEARING			D		

SPEECH

	ONSET MORE THAN 6 MONTHS	ONSET 6 MONTHS OR LESS
☐ NO IMPAIRMENT		
☐ IMPAIRMENT ☐ STRUCTURE OR MUSCULATURE OF VOCAL TRACT TYPE ____ ☐ LINGUISTIC SYSTEM		D
☐ COMPLETE LOSS		D
☐ DOES NOT SPEAK—NO KNOWN IMPAIRMENT		

DENTITION

	COMPENSATION TYPE	COMPENSATION NONE	DATE OF CHANGE
☐ NO TEETH MISSING OR FEW TEETH MISSING			
☐ SOME OPPOSING TEETH		D	
☐ NO TEETH OR NO OPPOSING TEETH		D	

FRACTURES/DISLOCATIONS

☐ NONE

	LOCATION TREATMENT	PREVIOUS REHABILITATION PROGRAM YES	PREVIOUS REHABILITATION PROGRAM NO OR NOT COMPLETED	ONSET MORE THAN ONE YEAR	ONSET ONE YEAR OR LESS
HIP FRACTURE(S)			D		D
OTHER FRACTURE(S)					
DISLOCATION(S)					

MISSING LIMBS

☐ NONE

	LOCATION	PREVIOUS REHABILITATION PROGRAM YES	PREVIOUS REHABILITATION PROGRAM NO OR NOT COMPLETED	ONSET MORE THAN ONE YEAR	ONSET ONE YEAR OR LESS
FINGER(S) OR TOE(S) ONLY			D		
BELOW ELBOW			D		
ABOVE ELBOW			D		
BELOW KNEE			D		
ABOVE KNEE			D		

PARALYSIS/PARESIS

☐ NONE

	LOCATION	PREVIOUS REHABILITATION PROGRAM YES	PREVIOUS REHABILITATION PROGRAM NO OR NOT COMPLETED	ONSET MORE THAN ONE YEAR	ONSET ONE YEAR OR LESS
MONOPLEGIA/PARESIS			D		D
HEMIPLEGIA/PARESIS			D		D
PARAPLEGIA/PARESIS			D		D
TRIPLEGIA/PARESIS			D		D
BILATERAL HEMIPLEGIA/PARESIS	▨		D		D
QUADRIPLEGIA/PARESIS	▨		D		D

ALLERGIES—SPECIFY

NAME OR NUMBER

DIAGNOSES

DIAGNOSES	DATE OF ONSET

RISK FACTOR MEASUREMENTS/OTHER TESTS

CIGARETTE SMOKING

☐ NEVER SMOKED ☐ DOES NOT SMOKE: HISTORY UNKNOWN

☐ EX-SMOKER ☐ SMOKES—# PER DAY ____

		RECORD DATE AND READING		
HEIGHT				
WEIGHT				
BLOOD PRESSURE				
BLOOD CHOLESTEROL				
BUN				
ALBUMINURIA				
BLOOD SUGAR-SPECIFY TEST				
HEMOGLOBIN OR HEMATOCRIT				
DIG. LEVEL SPECIFY TEST				
PROTHROMBIN TIME				
SERUM POTASSIUM				
OTHER				

JOINT MOTION

SPECIFY JOINTS AFFECTED

DATE				
WITHIN NORMAL LIMITS				
LIMITED MOTION d				
INSTABILITY—CORRECTED				
INSTABILITY—UNCORRECTED D				
IMMOBILITY D				

PAST MEDICAL HISTORY

FAMILY HISTORY

FUNCTIONING STATUS

MH - MECHANICAL HELP
HH - HUMAN HELP

NAME OR NUMBER

ACTIVITIES OF DAILY LIVING (ADL)

BATHING

DATE					
WITHOUT HELP					
MH ONLY					
HH ONLY	D				
MH AND HH	D				
IS BATHED	D				
DESCRIBE HELP					

DRESSING

WITHOUT HELP					
MH ONLY					
HH ONLY	D				
MH AND HH	D				
IS DRESSED	D				
IS NOT DRESSED	D				
DESCRIBE HELP					

TOILETING

WITHOUT HELP DAY AND NIGHT					
MH ONLY					
HH ONLY	D				
MH AND HH	D				
DOES NOT USE TOILET ROOM	D				
DESCRIBE HELP					

TRANSFERRING

WITHOUT HELP					
MH ONLY					
HH ONLY	D				
MH AND HH	D				
IS TRANSFERRED	D				
IS NOT TRANSFERRED	D				
DESCRIBE HELP					

BOWEL FUNCTION

CONTINENT					
INCONTINENT LESS THAN WEEKLY					
OSTOMY-SELF CARE					
INCONTINENT WEEKLY OR MORE	D				
OSTOMY—NOT SELF CARE	D				
TYPE OF OSTOMY, OTHER PROBLEM					

BLADDER FUNCTION

DATE					
CONTINENT					
INCONTINENT LESS THAN WEEKLY					
EXTERNAL DEVICE SELF CARE					
INDWELLING CATHETER SELF CARE					
OSTOMY SELF CARE					
INCONTINENT WEEKLY OR MORE	D				
EXTERNAL DEVICE NOT SELF CARE	D				
INDWELLING CATHETER NOT SELF CARE	D				
OSTOMY NOT SELF CARE	D				
TYPE OF OSTOMY OTHER PROBLEM					

EATING/FEEDING

WITHOUT HELP					
MH ONLY					
HH ONLY	D				
MH AND HH	D				
SPOON FED	D				
SYRINGE OR TUBE FED	D				
FED BY IV OR CLYSIS	DD				
DESCRIBE HELP					

BEHAVIOR PATTERN

APPROPRIATE	I				
WANDERING/PASSIVE LESS THAN WEEKLY	I				
WANDERING/PASSIVE WEEKLY OR MORE	d				
ABUSIVE AGGRESSIVE DISRUPTIVE— LESS THAN WEEKLY	D				
ABUSIVE AGGRESSIVE DISRUPTIVE— WEEKLY OR MORE	DD				
COMATOSE					
TYPE OF INAPPROPRIATE BEHAVIOR					

ORIENTATION

ORIENTED	I				
DISORIENTED—SOME SPHERES SOME TIME	d				
DISORIENTED—SOME SPHERES ALL TIME	d				
DISORIENTED—ALL SPHERES SOME TIME	D				
DISORIENTED—ALL SPHERES ALL TIME	D				
COMATOSE					
SPHERES AFFECTED					

MOBILITY LEVEL

DATE					
GOES OUTSIDE WITHOUT HELP					
GOES OUTSIDE MH ONLY	D				
GOES OUTSIDE HH ONLY	D				
GOES OUTSIDE MH AND HH	D				
CONFINED MOVES ABOUT	D				
CONFINED—DOES NOT MOVE ABOUT	D				
DESCRIBE HELP					

WALKING

WITHOUT HELP					
MH ONLY					
HH ONLY					
MH AND HH					
DOES NOT WALK					
DESCRIBE HELP					

WHEELING

DOES NOT—WALKS					
WITHOUT HELP					
MH ONLY					
HH ONLY					
MH AND HH					
IS WHEELED					
IS NOT WHEELED					
DESCRIBE HELP					

STAIRCLIMBING

WITHOUT HELP					
MH ONLY					
HH ONLY					
MH AND HH					
DOES NOT CLIMB					
DESCRIBE HELP					

COMMUNICATION OF NEEDS

VERBALLY—ENGLISH					
VERBALLY— OTHER LANGUAGE					
NONVERBALLY					
DOES NOT COMMUNICATE					
OTHER LANGUAGE NONVERBAL COMMUNICATION					

SERVICES CURRENTLY RECEIVED

FILL IN SPACES AS INDICATED

NAME OR NUMBER

THERAPIES

SPECIFY FREQUENCY

DATE				
INHALATION				
OCCUPATIONAL				
PHYSICAL				
SPEECH				
REALITY/ REMOTIVATION				
SOCIAL SERVICE				
OTHER				

OTHER SERVICES/SOCIAL CONTACTS

RECREATION/ ACTIVITIES				
RELIGIOUS SERVICES				
VISITORS				
OTHER				

NUTRITION

DIET—SPECIFY				
FOOD/FLUID (✓) INTAKE—NO PROB.				
PROBLEM—SPECIFY				
SUPPLEMENTAL NOURISHMENTS				
DINING LOCATION				

SPECIAL NURSING PROCEDURES

SPECIFY SITES WHERE APPLICABLE TYPE, AND FREQUENCY OF TREATMENT

DECUBITUS CARE SITE(S)				
DRESSING(S) SITE(S)				
EYE CARE—SPECIFY				
OXYGEN R_x— TYPE				
RESTORATIVE NURSING BOWEL/BLADDER TRAINING ROM EXERCISES SITES OTHER				
RESTRAINTS—SITES OF APPLICATION				
TEACHING OSTOMY CARE-TYPE SELF INJECTION OTHER				
OTHER SPECIAL NURSING				

PROFESSIONAL VISITS

SPECIFY FREQUENCY OF VISITS

ATTENDING MD/DO				
OTHER MD/DO				
AUDIOLOGIST				
DENTIST				
OPHTHALMOLOGIST/ OPTOMETRIST				
PODIATRIST				
OTHER				

MEDICATIONS

SPECIFY EACH MEDICATION BY CATEGORY INCLUDE DOSE, FREQUENCY, AND ROUTE OF ADMINISTRATION

DATE				
ANALGESICS/ NARCOTICS				
ANTACIDS				
ANTIBIOTICS/ ANTI-INFECTIVES				
ANTICOAGULANTS				
ANTIHYPERTENSIVES				
BOWEL REGULATORS				
CARDIAC REGULATORS				
DIURETICS/ ELECTROLYTES				
INSULIN/ HYPOGLYCEMICS				
SEDATIVES/ BARBITURATES				
TRANQUILIZERS/ ANTIDEPRESSANTS				
VASODILATORS				
VITAMINS/IRON				
OTHER				

MEDICATION ADMINISTRATION

NO MEDICATIONS				
SELF ADM., MONITORED LESS THAN WEEKLY				
BY LAY PERSONS, MONITORED LESS THAN WEEKLY				
BY LICENSED/PROF NURSE AND/OR MONITORED WEEKLY OR MORE C				
SOME OR ALL BY PROFESSIONAL NURSE D				

TRANSLATION TO SERVICE NEEDS

1. RECORD THE DATE OF ASSESSMENT.
2. MATCH THE ASSESSED STATUS RECORDED AS d, D, OR DD IN THE COMPLETED ASSESSMENT WITH THE SAME ITEMS IN THE ASSESSED STATUS COLUMN BELOW. CHECK THE SERVICE(S) NEXT TO EACH MATCHED ITEM UNDER THE DATE OF ASSESSMENT
3. MATCH THE ASSESSED STATUS FOR BEHAVIOR PATTERN WITH THAT OF ORIENTATION AND CHECK THE CORRESPONDING SERVICE AS NEEDED. IF THE ASSESSED STATUS IS "I" FOR BEHAVIOR AND ORIENTATION, NO SERVICE IS CHECKED AS NEEDED

NAME OR NUMBER

ADDITIONAL INFORMATION/PLAN

ASSESSED STATUS	SERVICE NEEDS	IF NEEDED, SERVICE OBTAINED FROM SERVICE PROVIDERS	SOCIAL SUPPORT
DATE		✓ OR SPECIFY. IF CHANGE OCCURS, RECORD DATE AND CHANGE	
NON-INSTITUTIONAL LIVING SPACE D Not Available	HOMEFINDING SERVICE		
SIGHT D IMPAIRMENT — NO (ATTEMPTED) COMPENSATION	OPHTHALMOLOGY/OPTOMETRY		
HEARING D IMPAIRMENT — NO (ATTEMPTED) COMPENSATION	AUDIOLOGY		
SPEECH D IMPAIRMENT SIX MONTHS AGO OR LESS — THERAPY NOT COMPLETED	SPEECH THERAPY		
DENTITION D SOME OR NO OPPOSING TEETH — NO COMPENSATION	DENTAL SERVICE		
FRACTURED HIP(S) DD — ONE YEAR AGO OR LESS AND REHABILITATION NOT COMPLETED	PHYSICAL THERAPY		
PARALYSIS/PARESIS DD — ONE YEAR AGO OR LESS AND REHABILITATION NOT COMPLETED			
MISSING LIMBS D REHABILITATION NOT COMPLETED			
JOINT MOTION INSTABILITY UNCORRECTED OR IMMOBILITY D			
LIMITED MOTION d	PROFESSIONAL NURSING		
EATING/FEEDING DD FED BY I.V. OR CLYSIS			
MEDICATION ADMINISTRATION SOME OR ALL BY PROFESSIONAL NURSE D			
BY LICENSED OR PROFESSIONAL NURSE d	LICENSED OR PROFESSIONAL NURSING		
ACTIVITIES OF DAILY LIVING ADL BATHING DRESSING TOILETING — D FOR 5, 6, OR 7 ADL	MEAL PREPARATION		
TRANSFERRING BOWEL FUNCTION BLADDER FUNCTION EATING/FEEDING — D FOR 2, 3, 4, 5, 6, OR 7 ADL	HOUSEKEEPING		
	ADL OR SUPERVISION BY LAY PERSONS OR AIDES		
BEHAVIOR — ORIENTATION I-APPROPRIATE OR WANDERING/PASSIVE LESS THAN WEEKLY AND d-DISORIENTED SOME SPHERES OR d-WANDERING/PASSIVE WEEKLY OR MORE AND I-ORIENTED			
I-APPROPRIATE OR WANDERING/PASSIVE LESS THAN WEEKLY AND D-DISORIENTED ALL SPHERES OR d-WANDERING/PASSIVE WEEKLY OR MORE AND d,D-DISORIENTED SOME OR ALL SPHERES OR D-ABUSIVE/AGGRESSIVE DISRUPTIVE LESS THAN WEEKLY AND I, ORIENTED d, OR D DISORIENTED	EMOTIONAL AND SOCIAL ASSESSMENT SERVICES		
DD-ABUSIVE/AGGRESSIVE/DISRUPTIVE WEEKLY OR MORE AND I, ORIENTED d, OR D DISORIENTED	EMOTIONAL AND SOCIAL TREATMENT SERVICES		
MOBILITY LEVEL D GOES OUTSIDE WITH HELP OR GOES NOT GO OUTSIDE	SHOPPING		
OTHER SERVICE NEEDS			

PREFERENCES FOOD	ACTIVITIES/HOBBIES/INTERESTS	OTHER

REASON FOR REFERRAL/DISCHARGE

IF DECEASED, CAUSE OF DEATH DATE

PHYSICIAN'S SIGNATURE

BEST COPY AVAILABLE

PHYSICIAN'S ORDERS FOR CARE	**NAME OR NUMBER**

PHYSICIAN'S SIGNATURE DATE DATE OF NEXT VISIT

I ( ) CERTIFY ( ) RECERTIFY THAT ( ) SKILLED NURSING CARE ( ) OTHER PROFESSIONAL SERVICES ARE REQUIRED BY THE BENEFICIARY ( ) ON AN IN-PATIENT BASIS **OR** ( ) ON AN INTERMITTENT BASIS FOR A BENEFICIARY CONFINED TO THE HOME, FOR CONDITION(S) ELIGIBLE FOR PRESUMED COVERAGE AS DESIGNATED IN THE ( ) MEDICARE ( ) __________ REGULATIONS. THE ABOVE PATIENT IS UNDER MY CARE AND AN ESTABLISHED PLAN OF CARE WILL BE REVIEWED BY ME AT LEAST EVERY _____ MONTHS.

PHYSICIAN'S SIGNATURE DATE

PHYSICIAN'S SIGNATURE DATE DATE OF NEXT VISIT

I ( ) CERTIFY ( ) RECERTIFY THAT ( ) SKILLED NURSING CARE ( ) OTHER PROFESSIONAL SERVICES ARE REQUIRED BY THE BENEFICIARY ( ) ON AN IN-PATIENT BASIS **OR** ( ) ON AN INTERMITTENT BASIS FOR A BENEFICIARY CONFINED TO THE HOME. FOR CONDITION(S) ELIGIBLE FOR PRESUMED COVERAGE AS DESIGNATED IN THE ( ) MEDICARE ( ) __________ REGULATIONS. THE ABOVE PATIENT IS UNDER MY CARE AND AN ESTABLISHED PLAN OF CARE WILL BE REVIEWED BY ME AT LEAST EVERY _____ MONTHS.

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PHYSICIAN'S SIGNATURE DATE

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PHYSICIAN'S SIGNATURE DATE

ADDITIONAL COMMENTS/JUSTIFICATIONS/RECOMMENDATIONS/DECISIONS

SIGNATURE AFFILIATION	SIGNATURE AFFILIATION	SIGNATURE AFFILIATION	SIGNATURE AFFILIATION

MODULE TITLE: Assessment of Older Clients

REFERRAL PLAN - ATTACHMENT C

SERVICE NEEDS	IF NEED	POTENTIAL FREQUENCY	SOCIAL SUPPORT WILL PROVIDE	AVAILABLE SERVICE PROVIDER	AVAILABLE METHODS OF PAYMENT	REFERRAL OPTIONS	PLAN SELECTED
Homefinding Service							
Ophthalmology Optemetry							
Audiology							
Speech Therapy							
Dental Service							
Physical Therapy							
Professional Nursing							
Licensed Nursing							
Meal Preparation							
Housekeeping							
ADL/Supervision by Lay Persons/Aides							
Emotional and Social Assessment or Treatment							
Shopping							
Other Transportation							

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ATTACHMENT D

MODULE TITLE: ASSESSMENT OF OLDER CLIENTS

CARE PLAN

PROBLEM	GOALS (Time Frame)	APPROACHES	CAREGIVER	GOAL ACHIEVEMENT
Date				

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WORKSHOP MODULE

June Soderstrom

TOPIC:

Meeting the Psychosocial Needs of the Home Bound Elderly

SYNOPSIS:

In this workshop, the vast subject of psychosocial needs will focus on the unique perspective of those older persons who become homebound. Special attention will be given to the role of service providers in helping the older person to meet these needs in the most effective and satisfying way possible.

RATIONALE:

As we move into an era when it is expected that the elderly will increase in numbers, their health condition will improve and their social status will be elevated, it is also anticipated that there will be an increased need and use of services that help the older person to stay in the home and in the community as long as possible.

Most older persons would prefer to care for themselves indefinitely, and thus remain independent as long as possible. The expansion and improvement of home care services is one way in which that goal might be realized. Another benefit of these services is that they may diminish the cost of health care for the elderly by delaying institutionalization. In addition, it would be hoped that these services would help improve the quality of life for the older person as well as his family and friends.

A major component of quality home care services is the incorporation of a basic understanding of the psychosocial needs of those elderly who are confined to the home. The purpose of this workshop is to provide the participants with the opportunity to gather information and examine skills which will contribute to an increased understanding of these needs. The service provider is in an appropriate position to help create a favorable home climate. This milieu may include helping with physical rehabilitation, providing a connection to the outside world and the promotion of self-management in the client. The efforts of the service provider can only be enhanced by an increased dimension of understanding and implementation of the fulfillment of the psychosocial needs of the homebound elderly.

RESOURCES:

1) Printed Materials

Bowling, Betty, Effective Patient Education Techniques for Use With the Aging Patient. The Center for Learning Resources, College of Allied Health Professionals, University of Kentucky, Lexington, Ky.: 1981.

This resource is designed to assist those health care professionals who provide patient education for elderly patients. It contains concrete information and specific materials which relate to such areas as communicating with older patients and the production of materials used to educate older persons in the areas of behaviors, attitudes, and feelings which will lead to better self-care.

Crandall, Richard, Gerontology, A Behavioral Science Approach. Addison Wesley Publishing Co., Menlo Park, Ca.: 1980. Chapter 11.

This book presents an extensive overview of the entire field of gerontology. In addition, much valuable statistical information is provided for the reader. Chapter 11, "Environment I: Home and Community," is especially helpful in guiding one to understand the "living" needs of older adults.

Miller, Dr. Juliet V., Working with Older People, A Resource. The National Center for Research in Vocational Education, The Ohio State University, Columbus, Oh.: 1981.

The purpose of this resource is to offer a collection of suggestions related to techniques which may be used in a variety of settings in which training is offered to people who in turn plan to be working with the elderly. Some specific materials are included such as presentation or leading techniques, simulation techniques and sources of additional materials.

Murray, Ruth Beckmann, M. Marilyn Huelskoetter and Dorothy O'Driscoll, The Nursing Process in the Later Years. Prentice-Hall, Inc., Englewood Cliffs, N.J.: 1980.

An extremely complete examination of the factors involved in the aging process. Although this book is directed to the nursing profession, with some technical and medical information, it can easily serve as a resource for paraprofessionals and other service providers.

Pegels, C. Carl, Health Care and the Elderly. Aspen Systems Corporation, Rockville, Md.: 1980.

This book is designed to examine the entire domain of health care for the elderly. It is intended to provide an unbiased overview of current and prospective health care delivery to the elderly. It contains statistical data obtained from many sources, including extensive use of government sources.

Stewart, Jane Emmert, Home Health Care. The C. V. Mosby Co., St. Louis, Mo.: 1979.

This book discusses current practices in the field of home health care. Further, it examines some of the major professional and economic influences which are affecting current practices. It is intended to be used as a handbook for all those who have contact with the home health industry.

Trocchio, Julie, Home Care for the Elderly. C.B.I. Publishing Co., Inc., Boston, Ma.: 1981.

This book is designed to help one learn the basics of home health care. It introduces basic concepts related to all phases of caring for the home-bound elderly. In addition, specific health care information is introduced.

2) Audio-visual Materials

Films

Almost a Miracle

A film on nursing services shows the visiting nurse through the eyes of patients and their families. Nurse helps family members understand and assist with nursing care, giving them a sense of participation.

Care at Home

Depicts the broad range of health services for the chronically ill and aged which, under various auspices, can be provided in the home. Patients and their families are interviewed and give reactions to the statement of advantages of such services.

Home Fires

Presents the salient aspects of the Homemaker-Home Health Aide Service - a form of assistance to families or individuals who cannot maintain living and household routines during a time of stress or crisis. In three case histories, the film shows the relationship between health or welfare agencies' staff and supervisors, as well as the duties and responsibilities of the Homemaker-Home Health Aide.

Home Health Aide

Describes selection, training and responsibilities of the home health aide. Film illustrates the relationship between the aide and other members of the home health team, and outlines aides' supervision and the degree of care aides can administer.

Home Bound Aged, The

Shows the special needs of the home-bound older persons and the ways nurses can work to meet these needs.

Long Day's Journey

Professional visiting nurse makes a day's rounds to private homes. Film stresses the importance of a good relationship between a nurse and her patients.

Films (cont.')

Passing Quietly Through

Concerns the efforts of a dying aged man to define the meaning of his quiet life in the sure knowledge that it is drawing to a close. The man lives alone in a shabby New York Hotel room, his only contact with the outside world is the welfare nurse who comes each day to care for him. The cynical nurse and dying patient achieve a small redemption because of their relationship with one another.

Filmstrips

Successful Aging, Parts I and II, CRM, Ca.

Discusses psychosocial perspectives of the aging process.

Physical Disabilities and their Implications, CRM, Ca.

3) Other Materials

Case Studies

Questionnaire on feelings about death

MODULE TITLE: Meeting the Psychosocial Needs of Home-Bound Elders

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
A. Identifying the psychosocial needs of the elderly.	1. Explain Maslow's theory - "Hierarchy of Needs" - for all people.	a. Lecture/discussion b. Handouts c. See Murray, Chapter 11, for leader's reference
	2. Describe normal age-related changes and their implications. (Include physiological, psychological, social and emotional)	a. Open discussion. Have participants "brainstorm" these changes. b. Lecture/discussion c. Handouts d. Show filmstrip, "Physical Changes and their Implications" (Perspectives on Aging Series)
	3. List sociological values and factors with which today's elder cohort would likely identify. (Include: independence, accepting no charity, etc.)	a. Discussion in small groups. Feedback to larger group. b. Open discussion - large group c. List on chalkboard d. Show filmstrip, "Successful Aging I" (Perspectives on Aging Series)
	4. Discuss special sociological factors which affect the status and functioning level of the elderly. (Include: economic, religious, educational, etc.)	a. Lecture/discussion b. See Murray, p. 282

MODULE TITLE: Meeting the Psychosocial Needs of Home-Bound Elders

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
B. Considering the needs and concerns of the home-bound elderly	1. Discuss the general implications for anyone who is home-bound. (Include: restrictions, limitations, emotions, etc.)	a. Lecture/discussion b. Handouts c. Experiential: use a fantasy scenario to imagine yourself to be home-bound. Share reaction.
	2. Describe physiological conditions which may typically intensify the problems of the home-bound elderly. (Include chronic and pathological conditions.)	a. Lecture/discussion b. Handouts
	3. Explain possible responses of the elderly upon becoming home-bound, as related to their mental health status. (Include: defense mechanisms, personality patterns, etc.)	a. Large group discussion. Record on newsprint. Later post. b. Small group discussion. Feedback to large group. Record on chalkboard. c. Lecture/discussion d. Role play. Have audience identify responses. e. See Crandall, p. 257; Murray, Chapter 11 f. Show film, "Care at Home"
C. Focusing on issues related to the care of the home-bound elderly.	1. Discuss the issues involved in the decision-making process. (Include: who, when, how, etc.)	a. Lecture/discussion b. Audience sharing

MODULE TITLE: Meeting the Psychosocial Needs of Home-Bound Elders

TOPICS	**STUDENT COMPETENCIES: At the end of the module, students should be able to--**	**SUGGESTED PRESENTATION METHODS**
	2. Understand important factors related to such issues as pain management, medications, prosthetic devices, etc.	a. Guest speaker (specialist) b. Lecture/discussion
	3. Describe basic, typical reactions of the elderly to loss, death and grief. (Include: Kubler-Ross' Five Stages, the terminally ill, etc.)	a. Show filmstrip, "Loss and Grief" (Perspectives on Aging Series) b. Use case studies
	4. Discuss family needs when their elderly relatives are home-bound. (Include: roles, responsibilities, relationships, etc.)	a. Small group discussion. Feedback to large group. b. Use case study. Share solutions. c. Role play - have audience identify problems and solutions. d. Lecture/discussion
D. Examining service roles and resources	1. Describe characteristics of effective service providers. (Include: a. Knowledge - personal hygiene, self-care, ADL, nutrition, etc. b. Skills - home management, communication, etc. c. Attitudes - concept of self and role, perception of client, etc.)	a. Guest speaker - representative from Home Care System b. Open discussion, large group. c. Handouts d. Lecture/discussion

MODULE TITLE: Meeting the Psychosocial Needs of Home-Bound Elders

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
	2. Describe resource possibilities. (Include: a. Professional - physician, dentist, nurse, psychiatrist, etc. b. Community - Meals-on-Wheels, day care centers, I&R, home care, etc. c. Personal - family, friends, neighbors, etc.)	a. Panel discussion - representatives from each area b. Lecture/discussion c. Handouts

ASSESSMENT

True-False

*True False 1. An age-related change which appears to be inevitable is the gradually declining ability to maintain and return to a homeostatic state.

True *False 2. All people move through the stages of reaction to loss and grief in the same way.

*True False 3. Normal age-related changes in cognitive functioning include the slowing down of reaction time.

True *False 4. It is clear that the elderly are always forced, against their will, to "disengage" from the activities of society.

True *False 5. Authorities agree that the patient who is terminally ill should not be told of his condition and impending demise.

True *False 6. The most important communication skills which the service provider can develop are those of verbal communication.

True *False 7. When gathering information regarding a client, the service provider should rely principally upon the medical records and history of the person.

True *False 8. Defense mechanisms which may be employed by the home-bound elderly are vastly different than those used by the general population.

*True False 9. Families of home-bound elderly may be in need of emotional support as much as physical support from the service provider.

True *False 10. Cultural values in the U.S. today are very stable and subject to very slow change.

Multiple Choice

1. The theory of personality development which is defined in terms of a "Hierarchy of Needs" is that of:

   a. Freud
   b. Erikson
   c. Rogers
   *d. Maslow
   e. White

2. Defense mechanisms which may be used by the home-bound elderly include:

   a. Projection
   b. Rationalization
   c. Sublimation
   d. Suppression
   *e. All of the above.
   f. None of the above.

3. Signs or symptoms of mental distress which may not be organic might include:

   a. Confusion
   b. Forgetfulness
   c. Hostility
   d. Suspicion
   *e. All of the above.
   f. None of the above.

4. Skills which one needs to develop and goals which one needs to reach in order to proceed most successfully from one stage in life to the next are usually called:

   a. dreams
   b. psychologist's expectations
   *c. developmental tasks
   d. All of the above.
   e. None of the above.

5. When service providers are working with an elderly client who is home-bound, they should work with:

   a. only with the elderly client
   b. primarily with the family of the patient
   *c. the client and his family as much as possible
   d. All of the above.
   e. None of the above.

SAMPLE WORKSHOP SCHEDULE

9:00 - 9:10 A.M.	Introduction of participants and instructors
9:10 - 9:15	Overview of the workshop objectives and the day's agenda
9:15 - 10:15	Filmstrip, "Successful Aging I" Lecture/discussion of basic human needs as related to the elderly, age-related changes and social-cultural values of the elderly.
10:15 - 10:30	Break
10:30 - 11:00	Film, "Care at Home." Reaction/discussion.
11:00 - 12:00	Lecture/discussion of factors affecting the responses of older people when they become home-bound. Fantasy scenario: being home-bound.
12:00 - 1:00 P.M.	Lunch
1:00 - 1:45	Lecture/discussion of special concerns of the home-bound elder person.
1:45 - 2:30	Case studies - small groups
	Large Group - share solutions
2:30 - 2:45	Break
2:45 - 3:45	Panel Discussion - Service Providers and Resources
3:45 - 3:55	Summary
3:55 - 4:00	Evaluation

WORKSHOP MODULE

James Ellor,
D.Min.

TOPIC:

Working with the Confused Elderly

SYNOPSIS:

Causes, assessment and treatment of the confused elderly are covered in this workshop.

RATIONALE:

Organic brain syndrome affects ten to fifteen percent of the aged and their families. Seemingly without provocation, confusion in the elderly can affect people from all walks of life and all educational backgrounds. The devastation to the individual, and to the family, due to the loss of cognitive functioning can be overwhelming. Until recently most human service workers were helpless to understand how to help such people. Thus nursing home placement and restraining devices were utilized to keep the effects of the confusion out of sight from the mainstream of society.

This workshop focuses on the most recent information as to causes of confusion, and teaches the participant the key principles of differential assessment and treatment. Emphasizing that while it may not be curable, it can be managed through work with the family, and the social environment. The goal of this workshop is to familiarize service providers with the central ideas in working with confused elders.

RESOURCES:

1) Printed materials

Angel, Ronald W., "Understanding and diagnosing senile dementia." Geriatrics, August, 1977, pp. 47-49.

Good article on diagnosing dementia.

Barns, Eleanor K., Ann Sack and Herbert Shore, "Guidelines to Treatment Approaches." The Gerontologist, Winter, 1973, pp. 513-527.

This article provides an overview of treatment approaches, including an excellent summary of the use of reality orientation.

Folsom, James C., Barbara Boies and Kenneth Pommerenck, "Life Adjustment Techniques for Use with the Dysfunctional Elderly." Aged Care and Service Review, Vol. 1, No. 4, 1978, pp. 1-10.

Useful review of the literature on treatment techniques, primarily for the confused elderly.

Goldfarb, Alvin I., Aging and Organic Brain Syndrome. Health Learning Systems, Inc., Bloomfield, N.J.: 1976.

1) Printed materials (cont.')

Extremely useful pamphlet discussing the effects of confusion in the aged on the senior, as well as the family. Also covers assessment utilizing the Kahn-Goldfarb/Face-Hand Test.

Mace, Nancy L. and Peter V. Rabins, The 36-Hour Day. The Johns Hopkins University Press, Baltimore, Md.: 1981.

Much acclaimed book particularly aimed at support of family caretakers.

Rathbone-McCaun, Eloise and Joan Hashimi, Isolated Elders. Aspen Publications, Rockville, Md.: 1982.

This book contains a chapter entitled, "Alzheimer's Disease and Isolation," that is helpful in dealing with the effects of confusion in the aged.

Wells, Charles E., "Chronic Brain Disease: An Overview." American Journal of Psychiatry, Vol. 135, No. 1, January, 1978, pp. 1-12.

This article provides an excellent overview of the various organic brain syndromes.

Wolanin, May Opal and Linda Ree Frachlich Phillips, Confusion/Prevention and Care, The C. V. Mosby Co., St. Louis, Mo.: 1981.

An excellent overview of cause, assessment and management of confusion in the aged from a nursing perspective.

2) Audio-visual materials

The Confused Person: Approaches to Reality Orientation (filmstrip)

Presents information about confused older patients and reality orientation, geared especially for nurses and other health care workers. Part of Concept Media's "Perspectives on Aging" series. 24 minutes.

The Silent Epidemic: Alzheimer's Disease (film)

Examines the causes and growing incidence of the disease and the problems it presents to family, community and health care facilities. Includes a poignant vignette of a husband's visit to his afflicted wife, a former artist. Filmakers Library. 25 minutes.

MODULE TITLE: Working with the Confused Elderly

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
A. Organic Brain Syndromes and the elderly, problems and prevalences and attitudes.	1. Describe the prevalence of O.B.S. and the history of the disease.	a. Lecture on the prevalence and the problems that are the result of confusion in the elderly.
	2. Identify the agist attitudes that contribute to the problem.	b. Design a brief self assessment attitudinal questionnaire on the topic of stereotypes of the aged in general, and the confused senior specifically. (This could be collated by a staff person, or each member of the audience collating as a part of a group discussion.)
	3. Briefly describe the reasons for concern with confusion in the aged.	c. Discuss cases and/or testimonials of family members who have felt the impact of a confused parent.
B. The Organic Brain Syndromes	1. Identify the various acute and chronic syndromes.	a. Lecture on the various syndromes utilizing handouts
	2. Describe the different cognitive deficits.	b. Have participants utilize the gestalt technique of closing their eyes and imagining what it would feel like to be confused. Discuss those feelings.
	3. Discuss the behavioral ramifications of the disease.	c. Break the audience into small groups of 5-6 people to create lists of the behaviors that they have observed in confused seniors.
C. Assessment of Brain Syndromes	1. Briefly discuss the resources for assessment (M.D., psychologist, etc etc.).	c. Brief lecture on the limitations of non-medical assessment of the confused senior, emphasizing the need for coordination with an M.D.
	2. Describe the necessary parts of an assessment.	b. Break the participants into groups of 5-6 to develop a list of the essential questions one would need to ask in order to gain sufficient background information on the patient, family and environment.

MODULE TITLE: Working with the Confused Elderly

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
	3. Describe the strengths and weaknesses of the various instruments used to assess cognitive functioning, particularly the MSQ.	c. Lecture on assessment instrument.
	4. Utilize the Kahn-Goldfarb face/hand test in practice with seniors.	d. Lecture on the steps needed to use the Kahn-Goldfarb face/hand test utilizing handouts. Have the group pair off and try the test on each other.
D. Treatment of elders with Organic Brain Syndrome	1. Discuss the major issues involved in the medical treatment of O.B.S. (Reflect the understanding that when O.B.S. is treatable, it should be done by an M.D.)	a. Lecture on the problems and the potential for medical treatment. Include broad information on pharmacological treatments.
	2. Identify the relationship between the types of brain damage and the various behaviors demonstrated by seniors.	b. Lecture on the correlations between parts of the brain and the ramifications for behavior.
	3. Identify the specific behaviors manifested by the confused person.	c. Lecture on the basic strategies of environmental and behavioral treatment.
	4. Identify the need for historical data on subjects of household routine and environment.	d. Utilize the lists of behaviors and the lists of questions needed for assessment generated earlier to discuss the use of this data in setting up either environmental or behavioral interventions.
	5. Briefly explain the correlations between environment, routine and behavior.	
	6. Describe the key concepts involved in modifying negative behaviors and supporting positive ones.	

MODULE TITLE: Working with the Confused Elderly

TOPICS	STUDENT COMPETENCIES: At the end of the module, students should be able to--	SUGGESTED PRESENTATION METHODS
	7. Describe some of the ways to reduce stress in the environment.	e. Break the participants into groups of 5-6 to discuss how they would utilize the above material to assist the client in a case history.
E. Helping family caretakers of confused elders	1. Identify the common problems faced by family caretakers.	a. Break the participants into groups of 4-5 to discuss the common issues they have encountered with family caretaking, generating a list of problems. Share lists with all participants paying particular attention to the issues of siblings, parent/child relationships and grandchildren.
	2. Discuss the effects of caretaking on the family.	
	3. Describe the issues in seeking support from extended family.	
	4. Describe the common concerns of grandchildren in caretaker families	
	5. Discuss the use of individual, family and group approaches to treatment.	b. Discuss the merits of the various treatment approaches.
	6. Discuss the use of supportive versus therapeutic approaches.	c. Role play a group sesssion, assigning the issues generated above to the actors.
	7. Identify the common coping patterns of family caretakers.	d. Handout and brief lecture on community resources for confused elders and their families.
	8. Describe the use of insight as well as educational approaches to treatment.	e. Wrap-up lecture summarizing the main points covered during the workshop.
	9. Locate resources and services available to assist confused elders and their families.	f. Have participants share one thing they've learned which they plan to use in their work setting and one thing which they'd like to learn next.

ASSESSMENT:

Please read each question carefully. For the first group of questions determine if the best answer is true or false and mark it accordingly.

1. T *F Arteriosclerosis is the major cause of confusion in the aged.

2. *T F While there are numerous reversible diagnoses for confusion in the aged, a majority of cases are not reversible.

3. T *F Pseudodementias refer to seniors who are faking confusion.

4. *T F Depression in the elderly can cause many of the same symptoms as an organic brain syndrome.

5. T *F The Kahn-Goldfarb face/hand test is a totally accurate assessment.

6. T *F Since many of the dementias are not reversible in the aged, there is nothing we can do to help.

7. *T F Confused seniors may display child-like behaviors, but they should not be treated like children.

8. T *F People who are confused have no feelings.

9. *T F One helpful treatment for confused seniors is to focus on a behavioral approach.

10.*T F One way to affect the behavior of seniors is to treat the anxieties and concerns of their families.

Please read each of the following questions,carefully selecting the proper answer.

11. Which of the following will not cause confusion in the aged?

a. Hypertension
b. Depression
c. Some types of medication
d. All of the above
*e. None of the above

12. The face/hand test requires which of the following?

a. Simultaneously touching the patient's face and hands
b. Touching both cheeks
c. Asking the patient to touch their nose
d. All of the above
*e. Both A and B

13. Which of the following is not a question on the Kahn-Goldfarb test?

    a. Where are we now?
    b. What month is it?
    c. What year were you born?
    *d. How old do I look?
    e. Who is president of the U.S.?

14. Treatment for confusion in the aged by non-physicians does not include:

    *a. Prescribing vitamins
    b. Reality Orientation
    c. Listening to their concerns
    d. Analyzing the environment for confusing objects
    e. Supportive counseling for families

15. Which of the following problems is best treated in a family group?

    a. Feeling alone with the problems
    b. Developing new ways to respond to undesirable behaviors
    c. Providing families with a place to vent frustrations with undesirable behaviors
    *d. All of the above
    e. None of the above

SAMPLE WORKSHOP SCHEDULE:

9:00 - 9:10 A.M.	Introduction of trainers and participants. Overview of workshop agenda and objectives.
9:10 - 9:30	Lecture on the prevalence and problems of O.B.S.
9:30 - 9:40	Administer questionnaire
9:40 - 10:00	Discuss questionnaire in light of attitudes toward aged.
10:00 - 10:30	Lecture on various O.B.S. diagnoses
10:30 - 10:40	Break
10:40 - 10:45	Gestalt experience
10:45 - 11:00	Break into small groups to generate lists of behaviors
11:00 - 11:15	Lecture on assessment
11:15 - 11:30	Break into small groups to generate lists of assessment questions.
11:30 - 11:45	Lecture on Kahn-Goldfarb face/hand test
11:45 - 12:30	Break into pairs to try out MSQ

12:30 - 1:30 P.M.	Lunch
1:30 - 1:50	Lecture on various aspects of treatment
1:50 - 2:10	Discuss how to use the list of behaviors and list of questions to begin to set up treatment
2:10 - 2:30	Break into small groups to discuss intervention with specific cases (handouts)
2:30 - 2:45	Break
2:45 - 3:10	Break into small groups to discuss common issues of families
3:10 - 3:20	Discuss problem lists generated by groups
3:20 - 3:40	Role play a group session
3:40 - 3:45	Wrap-up summary of highlights of workshop
3:45 - 3:55	Have each participant share one thing they learned in the workshop
3:55 - 4:00	Evaluation